(Eng. 1)

Wee Care PEDIATRICS

"For Parents Who Care To Give The Best!"

1950 S. Country Club Dr. #104, Mesa AZ 85210, 1919 East McKellips Road, #106, Mesa AZ 85203

(480) CHILDREN (244-5373) Fax: (480) 890-2201

PATIENT INFORMATION – Please enter for all children to be seen at the practice

CHILD'S NAME (LAST, FIRST,MIDDLE)	School (Now or next year)	DATE OF BIRTH	SEX	AHCCCS OR OTHER INS ID #
CHILD'S NAME (LAST, FIRST, MIDDLE)	School (Now or next year)	DATE OF BIRTH	SEX	AHCCCS OR OTHER INS ID #
CHILD'S NAME (LAST, FIRST, MIDDLE)	School (Now or next year)	DATE OF BIRTH	SEX	AHCCCS OR OTHER INS ID #
CHILD'S NAME (LAST, FIRST, MIDDLE)	School (Now or next year)	DATE OF BIRTH	SEX	AHCCCS OR OTHER INS ID #

PATIENT RACE- ○ American Indian or Alaska Native ○ Asian ○ Native Hawaiian/Other Pacific Islander ○ Black or African American ○ White ○ Hispanic ○ Other Race

PATIENT ETHNICITY- ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Refused to Report

PATIENT ADDRESS – Patient(s) reside(s) with: both parents ○ mother ○ father ○ other ______________________

ADDRESS (STREET AND APT OR P.O. BOX)	CITY	STATE	ZIP

PHARMACY INFORMATION – Where you want your prescriptions sent

PHARMACY NAME	ADDRESS OR MAJOR CROSS STREETS	PHONE

GUARANTOR INFORMATION – The person financially responsible for the patient, usually the one holding the insurance

NAME (LAST, FIRST, MIDDLE)	RELAIONSHIP TO PATIENT	SOCIAL SECURITY #

ADDRESS, *IF DIFFERENT FROM PATIENT* (STREET AND APT OR P.O. BOX)	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	DOB:	EMPLOYER	WORK PHONE

OTHER PARENT INFORMATION

NAME (LAST, FIRST, MIDDLE)	RELAIONSHIP TO PATIENT	SOCIAL SECURITY #

ADDRESS, *IF DIFFERENT FROM PATIENT* (STREET AND APT OR P.O. BOX)	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	DOB	EMPLOYER	WORK PHONE

INSURANCE INFORMATION – Please present insurance card(s) to the receptionist

PRIMARY INSURANCE (Company that will be billed first)	SECONDARY INSURANCE (Company that will be billed second, if one)

GROUP NUMBER	POLICY NUMBER	CO-PAYMENT	GROUP NUMBER	POLICY NUMBER	CO-PAYMENT

HOW DID YOU HEAR ABOUT US?

EMERGENCY CONTACT – When parents are not available

NAME (LAST, FIRST)	RELATIONSHIP	HOME PHONE	CELL PHONE

Consent to Obtain External Prescription History: I hereby authorize Wee Care and its providers to view my external prescription history via the Rxhub of the eClinical Works service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacies may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. My signature certifies that I read and understood the scope of my consent and that I authorize the access.

Parent/Guardian Signature: ____ **Date:** ________________________

Consent to Treat And/Or Release: I hereby authorize Wee Care and its providers to examine and treat me and/or my minor child when necessary. I also authorize the release of my/our protected health information (PHI), acquired in the course of examination to carry out treatment, payment and healthcare operations (TPO) on our behalf. This consent shall remain in effect until revoked in writing.

Parent/Guardian Signature: ____ **Date:** ________________________

Wee Care PEDIATRICS

"For Parents Who Care to Give the Best"

Practice Policies Consent Form

Patient's Name: ____________________ Patient's Date of Birth: ___/___/___

I certify that I have been offered a copy of the Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills in the performance of Wee Care Pediatrics. The Notice of Privacy Practices can also be found on the Wee Care pediatrics website at www.weecare4kids.com. Wee Care Pediatrics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the of my next appointment, or accessing the Wee Care website.

________ Initials

I have read, and I understand, the practice policies of Wee Care Pediatrics. I agree to be bound by those policies. I understand and agree that said terms might be changed by Wee Care Pediatrics as deemed necessary.

_______ Initials

I hereby assign to Wee Care Pediatrics all payment for medical services rendered to my child. Further, I understand that I am responsible for all charges incurred at Wee Care Pediatrics not covered by my insurance. I authorize Wee Care Pediatrics to provide information to insurance carriers concerning my child's illnesses and treatments.

_______ Initials

I authorize Wee Care pediatrics to render medical care and treatment, either routine or emergency, including physical examination and immunization administration. This consent covers today and any and all future visits or appointments I may schedule with the health care providers at Wee Care Pediatrics. I acknowledge that no guarantees have been made as to the effect of any examination or treatment of my child's (or children's) condition(s).

_______Initials

I acknowledge that I have received a copy of Wee Care Pediatrics "Notice of Privacy Practices". This notice describes how Wee Care Pediatrics may use and disclose my child's protected healthcare information and rights I may have regarding my child's protected health information.

_______ Initials

____ _______/_______/_______

Signature of Patient's Representative Date

____

Relationship to Patient

Patient Eligibility Screening Record
Vaccines for Children Program

This record must be kept in the healthcare provider's office to reflect the current status of all children 18 years of age or younger declared eligible to receive immunizations through the VFC program. The record may be completed by the parent, guardian, individual or record, or by the healthcare provider.
This same record may be used for all subsequent visits as long as the child's VFC eligibility status has not changed. Provider verification of responses is not required, but it is necessary to retain this record on file for a minimum of three years.

(Please print or type)
Today's Date: ______________________________

Child: ______________________________
Last Name First Name M.I.

Date of Birth: ________ / ________ / ________
Month/mes Day/dia Year/año

Parent/Guardian/
Individual of Record: ______________________________

Provider: WEE CARE PEDIATRICS

This child qualifies for vaccination through the VFC program because he/she (check only one box):

(0) [ ] is enrolled in KidsCare: or

(1) [ ] is enrolled in AHCCCS; or

(2) [ ] does not have health insurance; or

(3) [ ] is American Indian or Alaskan Native; or

(4) [ ] has health insurance that does not pay for vaccines

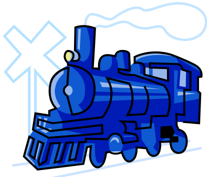
[ ] Check here if this child has health insurance that pays for vaccines.
These children do not qualify for VFC

Please be advised, if your insurance company does not cover immunizations and you do not let us know at the time of the visit, it is your responsibility to pay the cost involved. We cannot make Vaccines For Children Program retroactive and you are only eligible for Vaccines For Children Program at the time of the visit. If you are unsure if immunizations and well check-ups are covered, please contact your insurance company.

Thank You

Signature: ______________________________ Date: ______________________

Scan: Medinotes\Patient View\Name of Patient\Multimedia\Authorization: (type in Pt. Inf.) This page to be scanned with Pt. Pages 1 and 2 altogether



Wee Care Pediatrics
1950 S. Country Club Dr. Suite 104 Mesa, AZ 85210
1919 East McKellips Road, #106, Mesa AZ 85203
Phone: 480-CHILDREN (244-5373) Fax: 480-890-2201

Medical History

Today's Date: ___________
Name of the Patient ____Date of Birth: ____________________
Name of person completing this form ____
Patient Sex: M F Social Security # __________-__________-________________
How many people live with this patient? Adult's ___________ Children ________

Patient's Birth History: Birth weight ________________ Length _______________
During the pregnancy did the patient's mother:
Have any medical problems or complications? Yes No
If yes, please explain: ____
Smoke tobacco? Yes No
Drink alcohol? Yes No
Used any drugs or medications? Yes No
If yes, please explain: ____
Have any problems with labor or delivery? Yes No
If yes, please explain ____
Was the delivery: Vaginal Cesarean

Patient past Medical History

Overall health is: Good Fair Poor
Allergies to any medication? Yes No If yes, which medication ______________________________
What happens? ____
Currently taking any medications? Yes No
If yes, which medication? ____
Smoke tobacco? Yes No
Drink alcohol? Yes No
Use any drugs? Yes No
If yes, please explain: ____

Has the patient ever had any problems with any of the following? If yes, please explain.
Eyes/Vision Yes No ____
Ears/Nose/Throat Yes No ____
Headaches Yes No ____
Joints/Bones Yes No ____
Seizures Yes No ____
Repeated Infections Yes No ____
Heart/Lungs Yes No ____
Stomach/Liver Yes No ____
Intestines/Colon Yes No ____
Kidneys/Urine Yes No ____
Indigestion/Nutrition Yes No ____
Anemia/Bleeding Yes No ____
Patient past Medical History Continued:
Scan: Medinotes\Patient View\Multimedia\PMH: (Type in: PMH)

Please list any surgeries, hospitalizations, serious illnesses or accidents with dates:
_______________________________ Date _________ ________________________ Date _________
_______________________________ Date _________ ________________________ Date _________
_______________________________ Date _________ ________________________ Date _________

Do you, as a parent, have any concerns about any of the following? If yes, please explain.

Growth/Development?	Yes	No	________________
Behavior?	Yes	No	________________
Eating habits?	Yes	No	________________
Sleeping habits?	Yes	No	________________
School?	Yes	No	________________
Bathroom/Toilet?	Yes	No	________________
Discipline?	Yes	No	________________
Other?	Yes	No	________________

Are Immunizations up to date? Yes No

Female Patients Only:

Are you having menstrual cycles? Yes No
Menstrual Period last Date? _____________
How many pregnancies? ____________
Number of Living children? _______________
Use birth control? Yes No

At what age did menstruation began? ___________
Are you cycle regular? _______________________
Number of births? ___________
Last pap? ____________
Name of Birth control? _________________

Patient's Family Medical History

Does any family member have any of the following medical conditions? If yes, please explain and state the relation with the patient (uncle, cousin, maternal grandfather, etc.)

Heart disease	Yes	No	________________
Tuberculosis	Yes	No	________________
High blood pressure	Yes	No	________________
Kidney disease	Yes	No	________________
Allergies/Asthma	Yes	No	________________
Cancer	Yes	No	________________
Bleeding disorder	Yes	No	________________
Diabetes	Yes	No	________________
Psychiatric problems	Yes	No	________________
Seizures	Yes	No	________________
Rheumatic fever	Yes	No	________________
Genetic disorder	Yes	No	________________
Thyroid disease	Yes	No	________________
Lung disease	Yes	No	________________
Bone/Joints	Yes	No	________________

Other ____

To the best of my knowledge all the information provided is accurate and true.

____ Date: _________________
(Signature of person completing form)

Reviewed by: ____________ ____________
Provider M.A.

Scan: Medinotes\Patient View\Multimedia\PMH: (Type in: PMH)

Patient Authorization to Transfer Medical Records

or Disclose Other Protected Health Information to Wee Care Pediatrics

By signing this authorization, I authorize release of medical records of the following:

____ Whose DOB is_________________

Name of Patient (Month/Day/Year)

From:

Office Name: ____

Doctor's Name: ____

Address: ____

Phone#: (_________)___________________________

Fax#: (_________)___________________________

To:

Wee Care Pediatrics
1950 S. Country Club Dr. Suite 104
Mesa, AZ 85210
Phone 480-CHILDREN (244-5373), Fax 480-890-2201

Please transfer and/or disclose the following information:

☐ All Medical records, files, charts, reports and other associated health information

OR

☐ The following specific Protected Health Information (PHI) (check all that apply)

__ Medical Records & Charts __Immunizations Records __ X-Rays or Diagnostics

__ Lab Results __ Others (Please Specify) ______________________________

I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand I do not have to sign this authorization in order to get health care benefits. I understand that I have the right to revoke this authorization at any time in writing, except to the extent that the medical provider named above or Wee Care Pediatrics has acted in reliance upon the authorization. I also understand that records may take 7 working days to process.

Relationship to Patient:
Name of Parent/Legal Guardian:
Address:
Phone Number:
Signature:
Date:

******Please mail records over 25 pages. Thank you!******

Parent Authorization for another to give medical service

Date: ____________
Time: ____________ am/pm

To Whom It May Concern:

Due to _________________________ (Circumstance), I __________________ (legal guardian) to hereby authorize _________________________ (person being authorized) to take my child _________________________________ (child name) Date of birth ____________(child DOB) to any and all medical visits, attain prescriptions and any other necessary medical needs for my child until _____________ (date).

You may communicate to me at (   ) ________- __________ (phone #) if you have any questions.

Sincerely,

Legal Guardian

Wee Care Pediatrics: For Parents Who Care to Give the Best!

1950 S. Country Club Dr. #104 Mesa, AZ 85210, 1919 East McKellips Road, #106, Mesa AZ 85203
Tel. (480) CHILDREN (244-5373) Fax: (480) 890-2201

Practice Policies

Office Hours:
(Appointment Scheduling & phone answering hours)
From 8:00 AM until 8:00 PM Monday through Thursday
From 8:00 AM until 2:30 PM Friday
From 10AM-2PM: Various Saturdays of each month, please call.
The office is closed on Sundays

At all other times, you may call to ***<u>(480) CHILDREN</u>*** *(244-5373)* and leave a detailed message including the following information:

* Your Name
* Patient's Name
* Phone number where you can be reached and
* Reason for your call

For emergencies, the doctor is called by our answering service.

Appointments Availability:
-Urgent care or sick visits:
Urgent care or sick visits can usually be made for the same day. You may be asked to schedule an appointment and return later. The office is closed daily from 12:30 PM to 2:30 PM

-Well Child exams:
Well Child exams are scheduled at the following ages: ***3-5days, 2 weeks, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, 3years then once a year***. It is best to schedule your next well exam when you check out following your office visit. Appointments can usually be made as early as 6 months prior to the anticipated exam date.

Sports Physicals
Sports and camp physicals are usually performed during summer months. Please call early summer or late spring for appointments. Many Insurance companies only cover 1 physical exam a year. You may want to schedule your sports and physical exam needs on one visit.

Cancellations:
Twenty-four (24) hour notice is required if you are unable to keep an appointment. Because appointments fill quickly, it will be necessary to charge up to a forty dollar ($40) fee, if we are not notified or you do not show for an appointment.

Medication Refills:
-Regular requests
If you are requesting a refill on your medication, please schedule an appointment so that your child may be evaluated. It is our policy to insure that children not only get the medication they need, but to evaluate the need for further medication. Prescriptions for antibiotics will only be called in to pharmacies in response to testing ordered by the Pediatrician.

-Urgent requests
If your child's symptoms are severe enough and cannot wait until the next day, we may direct you to one of the urgent care facilities or hospital emergency rooms. Each insurance plan may contract with different after hours facilities.

Newborn Notification:
Although your newborn has been cared for in the hospital, your insurance company has not been notified. <u>It is your responsibility to call your insurance carrier or the human resource person where you work to insure your child</u>. We advise you to document when you have made your call and with whom you have spoken. Most insurance companies cover your newborn for the first 30 days after birth. Your child must be enrolled within 30 of birth. Please follow up on your call to confirm enrollment and insurance coverage.

Immunizations:
Immunizations represent a very important aspect of your child's preventive healthcare. It may also be the most expensive part. Many times your insurance may not cover all immunizations after 5 years of age. There may be a dollar limit on all well visits which include immunizations and well exam. You may qualify for the vaccine for children program, if you do not have medical insurance.

Insurance Benefits:
We try to contact many insurance companies prior to your appointment. Please let us know if your insurance has changed. Insurance coverage differs from one employer to another. **It is the responsibility of the patient and his family to understand the limits of their insurance coverage.**

Billing Questions:
We strive to insure that all information is entered correctly. If you feel that an error has been made in your account call the office at (480-CHILDREN). Payment may be made by cash, credit card, or debit card. We do not accept personal checks

Co-Payments:
Most insurance plans require their enrollees to make a co-payment whenever they seek medical attention. It may be a violation of your contract to refuse to make your co-payment prior to being seen at the office. That payment may represent as much as 50% of the total reimbursement. Please be prepared to make your co-payment when checking in at the reception desk.

Wee Care Pediatrics

A Division of Wee Care Family Clinic, Corp.
1950 S Country Club Dr, Suite 104 – Mesa – Arizona – 85210
1919 East McKellips Road, #106, Mesa AZ 85203

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Our goal is to take appropriate steps to attempt to safeguard any medical of other personal information that is provided to us. We are required to: (1) maintain the privacy of medical information provided to us; (2) provide notice of our legal duties and privacy practices; and (3) abide by the terms of our Notice of Privacy Practices currently in effect.

WHO WILL FOLLOW THIS NOTICE

This notice describes the practices of our physicians, employees and staff.

INFORMATION COLLECTED ABOUT YOU

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as:

- Your name, address and phone number.
- Information relating to your medical history.
- Your insurance information and coverage.
- Information concerning your doctor, nurse or other medical providers.

In addition, we will gather certain medical information about you and will create a record of the care provided to you. Some information also may be provided to us by other individuals or organizations that are part of your "circle of care" – such as the referring physician, your other doctors, you health plan, and close friends or family members.

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU

We may use and disclose personal and identifiable health information about you in different ways. All of the ways in which we may use and disclose information will fall within one of the following categories, but not every use or disclosure in a category will be listed.

MANDATORY ELEMENTS

For Treatment. We will use health information about you to furnish services and supplies to you, in accordance with our policies and procedures. For example, we will use your medical history, such as any presence or absence of heart disease, to assess your health and perform requested diagnostic services.

For Payment. We will use and disclose health information about you to bill for our services and to collect payment from you or your insurance company. For example, we may need to give a payer information about your current medical condition so that it will pay us for the examinations or other services that we have furnished you. We may also need to inform your payer of the tests that you are going to receive in order to obtain prior approval or to determine whether the services is covered.

For Health Care Operations. We may use and disclose information about you for the general operation of our business. For example, we sometimes arrange for accreditation organizations, auditors or other consultants to review our practice, evaluate our operations, and tell us how to improve our services.

Public Policy uses and Disclosures. There are a number of public policy reasons why we may disclose information about you.

We may disclose health information about you when we are required to do so by federal, state, or local law.

We may disclose protected health information about you in connection with certain public health reporting activities. For instance, we may disclose such information to a public health authority authorized to collect or receive PHI for the purpose of preventing a controlling disease, injury or disability, or at the direction of a public health authority, to an official of the foreign government agency that is acting in collaboration with a public health authority. Public health authorities include state health departments, the Center for Disease Control, the Food and Drug Administration, the Occupational Safety and health Administration and the environmental Protection Agency, to name a few.

We are also permitted to disclose protected health information to a public health authority or other government authority authorized by law to receive reports of child abuse or neglect. Additionally we may disclose protected health information to a person subject to the Food and Drug Administration's power for the following activities: to report adverse events, product defects or problems, or biological products deviations, to track products, to enable product recalls, repairs or replacements, or to conduct post marketing surveillance.

We may disclose your protected health information in situations of domestic abuse or elder abuse.

We may disclose protected health information in connection with certain health oversight activities of licensing and other agencies. Health oversight activities include audit, investigation, inspection, licensure or disciplinary actions, and civil, criminal, or administrative proceedings or actions or any other activity necessary for the oversight of 1) the health care system, 2) governmental benefit programs for which health information is relevant to determining beneficiary eligibility, 3) entities subject to governmental regulatory programs for which health information is necessary for determining compliance with program standards, or 4) entities subject to civil rights laws for which health information is necessary for determining compliance.

We may disclose information in response to a warrant, subpoena, or other order of a court or administrative hearing body, and in connection with certain government investigations and law enforcement activities.

We may release personal health information to a coroner or medical examiner to identify a deceased person or determine the cause of death. We also may release personal health information to organ procurement organizations, transplant centers, and eye or tissue banks.

We may release your personal health information to workers' compensation or similar programs.

Information about you also will be disclosed when necessary to prevent a serious threat to your health and safety or the health and safety of others.

We may use or disclose certain personal health information about your condition and treatment for research purposes where and Institutional Review Board or a similar body referred to as a Privacy Board determines that your privacy interests will be adequately protected in the study. We may also use and disclose your protected health information to prepare or analyze a research protocol and for other research purposes.

If you are a member or the armed forces, we may release personal health information about you as required by military command authorities. We also may release personal health information about foreign military personnel to the appropriate foreign military authority.

We may disclose your protected health information for legal or administrative proceedings that involve you. We may release such information upon order of a court or administrative tribunal. We may also release protected health information in the absence of such an order and in response to a discovery or other lawful request, if efforts have been made to notify you or secure a protective order.

If you are an inmate, we may release protected health information about you to a correctional institution where you are incarcerated or to law enforcement officials.

Finally, we may disclose protected health information for national security and intelligence activities and for the provision of protective services to the President of the United States and other officials or foreign heads of state.

Our Business Associates. We sometimes work with outside individuals and businesses that help us operate our business successfully. We may disclose your health information to these business associates so that they can perform the tasks that we hire them to do. Our business associates must guarantee to us that they will respect the confidentiality of your personal and identifiable health information.

Individuals Involved in your care or Payment for Your Care. We may disclose information to individuals involved in your care or in the payment for your care, but we will obtain your agreement before doing so. This includes people and organizations that are part of your "circle of care" – such as your spouse, your other doctors, or an aide who may be providing services to you. Although we must be able to speak with your other physicians or health care providers, you can let us know if we should not speak with other individuals, such as your spouse or family.

[To the extent another state or federal law restricts the ability of the practice to use or disclose protected health information as discussed above, the practice's description of the use or disclosure must reflect the more stringent law.]

ADDITIONAL OPTIONAL ELEMENTS

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment or that you should schedule an appointment.

Treatment Alternatives. We may use and disclose your personal health information in order to tell you about or recommend possible treatment options, alternatives or health-related services that may be of interest to you.

Fundraising. We may use your protected health information to contact you in an effort to raise funds for our operations.

OTHER USES AND DISCLOSURES OF PERSONAL INFORMATION

We are required to obtain written authorization from you for any other uses and disclosures of medical information other than those described above. If you provide us with such permission, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose personal information about you for the reasons covered by your written authorization. We will be unable to take back any disclosures already made based upon your original permission.

INDIVIDUAL RIGHTS

You have the right to ask for restrictions on the ways in which we use and disclose your medical information beyond those imposed by law. We will consider your request, but we are not required, to accept it.

You have the right to request that you receive communications containing your protected health information from us by alternative means or at alternative locations. For example, you may ask that we only contact you at home or by mail.

Except under certain circumstances, you have the right to inspect and copy medical and billing records about you. If you ask for copies of this information, we may charge you a fee for copying and mailing.

If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or correct the missing information. Under certain circumstances, we may deny your request.

You have the right to ask for a list of instances when we have used or disclosed your medical information for reasons other than your treatment, payment for services furnished to you, our health care operations, or disclosures you give us authorization to make. If you ask for this information from us more than once every twelve months, we may charge you a fee.

You have the right to a copy of this Notice in paper form. You may ask us for a copy at any time. To exercise any of your rights, please contact us in writing at Wee Care Pediatrics 1950 S. Country Club Dr., Suite 104, Mesa, AZ 85210.

CHANGES TO THIS NOTICE

We reserve the right to make changes to this notice at any time. We reserve the right to make the revised notice effective for personal health information we have about you as well as any information we receive in the future. In the event there is a material change to this Notice, the revised Notice will be posted. In addition, you may request a copy of the revised Notice at any time.

COMPLAINTS/COMMENTS

If you have any complaints concerning our Privacy Policy, you may contact the Secretary of the Department of Health and Human Services, at 200 Independence Avenue, S.W., Room 509F, HHH building, Washington, D.C. 20201 (e-mail: **ocrmail@hhs.gov**). You also may contact us at Wee Care Pediatrics, Attn: Randy Payan, Office Administrator, 1950 S Country Club Dr., Suite 104, Mesa, AZ 85210, (480) CHILDREN (244-5373).

To obtain more information concerning this notice of Privacy Practices, you may contact our Privacy Officer at (480) CHILDREN, Randy Payan, Administrator.

This privacy Policy is effective August 7, 2006.