North Fulton Pediatrics

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 CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information (PHI) is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communication from us. ***Please Note: sending North Fulton Pediatrics, PC your medical records information or test results from other physicians via email is NOT Secure or HIPAA compliant. If you send us patient information, you do so, at your own risk.***

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we much abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of January 1, 2016 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by your office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer, Brenda Waters, at (770) 442-1050 ext. 216

Privacy Notice Acknowledgment

I acknowledge that I have received, read and understand the Notice of Privacy Practices.

_____ _____

Patient/Parent/Guardian Signature Date

_____

Print Name

North Fulton Pediatrics

North Fulton Pediatrics, PC

Authorization to Disclose Medical Information

This authorization permits North Fulton Pediatrics, PC to disclose my protected health information to the following third party or parties. (Relatives, Guardians and/or friends) I understand that this authorization will last until I specify changes.

1. _____ 2. _____ 3. _____
   Full Name Full Name Full Name

1. _____ 2. _____ 3. _____
   Relationship to patient Relationship to patient Relationship to patient

Please read and initial the following statements:

_____ I understand that the information disclosed may be further disclosed by the above-named third party and it may no longer be protected by the Final Privacy Rule.

_____ I understand that I may revoke this authorization in writing to North Fulton Pediatrics, PC Attention Chief Privacy Officer, Brenda Waters, 1285 Hembree Road, Suite 100, Roswell, GA 30076.

____ I understand that I have the right to refuse to sign this authorization and that my treatment, payment for my healthcare, and health care benefits will not be affected if I do not sign this form. Our policy is to write in the signature line, Patient/Parent/Guardians Name, “Refuses to Sign”.

_____ _____

Patient/Parent/Guardian Signature Date

Financial Policy

Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines.

1. You are ultimately responsible for payment of charges for services you receive from our office. Certain procedures are non-covered services under all insurance policies, therefore, payment is expected at the time of service. There will be a $15 fee if your copay is not paid within 24 hours of your office visit.
2. It is your responsibility to provide us with your current address, telephone number, social security number and insurance information at each visit.
3. It is your responsibility to contact your insurance carrier to confirm that the doctor you are seeing is a participant of your plan.
4. We will mail you ONLY 2 monthly statement for any outstanding balances. If this balance should proceed to collections, you will be responsible for the 20% collection fee. If your insurance carrier has not paid the claim within 30 days of the date of service, please contact your insurance company and assist us in getting your child's claim paid.
5. We will only file insurance up to 3 months per claim. At that time, payment is due in full by the patient. If no payment is made on the account after the 4th month, your account may automatically be turned over to collections.
6. At the time of your visit, please be prepared to pay your co-payment, co-insurance and any unpaid deductible required by your insurance company. We know what your insurance company allows and can give you an estimate by calling our Billing Department.
7. As of 2018, we will request a "Credit Card On File", unless other arrangements are made with a payment plan. Deductibles are high for 2018 and we can no long carry balances as we did before. We want to stay a private physician's office and in order to stay a private entity, we need your help with any balances that you may incur. Your card will NOT be charged until you have been notified and a receipt will be sent to your address on file.
8. We truly appreciate you choosing North Fulton Pediatrics and are honored that you chose us to care for your child(ren). We don't take this lightly and are willing to work with you on any balance you may incur at North Fulton Pediatrics.

_____ _____

Patient Signature / Responsible Person Date

_____

Print Name / Patient / Responsible Person

Credit Card On File Policy

At North Fulton Pediatrics, PC, we require keeping your credit card on file as a convenient method payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of $10 will be added to your account for any balances that we must attempt to collect through mailing monthly statements. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will charge for each month that the bill remains unpaid. Your Credit Card (debit) information will be kept under lock and key and then the office will be locked as well. North Fulton Pediatrics will protect your information as if it were our own information.

Your credit card information is kept confidential and secure and payments to your card are processed **ONLY** after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account. You will be notified prior to any charges and a receipt will be sent to the email address on file.

I authorize North Fulton Pediatrics to charge the portion of my bill that is my financial responsibility to the following credit or debit card. I understand that 3 attempts will be made by text, phone, or email prior to any charges being posted to your credit card or debit card.

□ **Amex** □ **Visa** □ **Mastercard** □ **Discover**

Credit Card (Debit) Number: _____

Expiration Date: _____/_____/20___ CVV code: _____

Cardholder Name: _____

Signature: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

I (we), the undersigned, authorized and request North Fulton Pediatrics, PC, to charge my credit card (debit), indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by North Fulton Pediatrics, PC.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to North Fulton Pediatrics, PC in writing, C/O of the: Billing Department, and the account must be in good standing.

Patient/Parent/Guardian (Print): _____

Patient/Parent/Guardian Signature: _____

Date: _____/____/20___