Notice of Privacy Practices
Effective April 14, 2003

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.

1. **Introduction**- This Notice of Privacy Practices describes how Pediatric Associates of Lewiston P.A. may use and disclose your protected health information ("PHI") to provide treatment to you; to seek payment for the medical services you receive; and to support legitimate health care operations of our practice.

"PHI" includes your demographic information such as name, address, telephone number, and family; past, present, or future information about your physical or mental health or condition; and information about the medical services provided to you, including payment information, if any of that information be used to identify you.

The Notice describes uses and disclosures of PHI to which you have consented, that you may be asked to authorize in future, and that are permitted or required by state or federal law. Also, it advises you of your rights to access and control your PHI.

This Notice is effective April 14, 2003. We may amend this Notice of Privacy Practices periodically and you may obtain a current copy of the Notice by contacting the office staff at any time.

We regard the safeguarding of your PHI as an important duty. The elements of this Notice, the consent you have signed, and any authorizations you may sign are required by state and federal law for your protection and to ensure your informed consent to the use and disclosure of PHI necessary to support your relationship with Pediatric Associates of Lewiston, P.A..

If you have any questions about Pediatric Associates of Lewiston P.A. Notice of Privacy Practices, please contact our Office Manager, Jen Giles, at 207-784-5782, 33 Mollison Way, Lewiston, ME 04240.

2. **Safeguarding PHI Within the Office**

We have in place appropriate administrative, technical, and physical safeguards to protect the privacy of your PHI. We regularly train our staff on the obligation to protect the privacy of your PHI. We hold medical records in a secure area within the office. Only staff members who have a "need to know" are permitted access to your medical records and other PHI. Our staff understands the legal and ethical obligation to protect your PHI and that a violation of this Notice of Privacy Practices will result in discipline in accordance with our personnel policy.

3. **Uses and Disclosures of PHI Based Upon Your Written Consent**

You signed our "Consent to Use and Disclosure of Protected Health Information" when you joined our practice. Based upon this consent, our practice will use and disclose your PHI for the following types of activities:

- **Treatment.** Treatment means the provision, coordination, or management of your health care and related services by Pediatric Associates of Lewiston P.A. and other health care providers involved in your care. It includes the coordination or management of health care by a provider with a third party, consultation between our practice and other health care providers relating to your care, or our practice's referral of you to a specialist physician or other practitioner or facility, such as a laboratory.
- **Payment**. Payment means our activities to obtain reimbursement for the medical services provided to you, including billing, claims, management, and collection activities. Payment also may include your insurance carrier's work in determining eligibility, claims processing, assessing medical necessity, and utilization review.
- **Health Care Operations**. Health care operations mean the legitimate business activities of our medical practice. These activities include, for example, quality assessment and improvement activities; practitioner performance evaluation; fraud and abuse compliance; business planning and development; and business management and general administrative activities. For example, we may verify your home address, phones numbers and insurance information at the front desk; we may call you by name in the waiting room when we are ready to serve you; and we may remind you of your appointment by mailing you a postcard and/or leaving a message on your answering machine or voicemail. Also, we may send you a newsletter about our practice. When we involve third parties, such as billing services, in our business activities, we will have them sign a "business associate" agreement obligating them to safeguard your PHI according to the same legal standards we follow. If we maintain a facility directory, we will include your name, a general statement about your condition, your religious preference, and your location in the facility.
- **Family and Close Friends Involved in Your Care**. You have consented to disclosure of PHI that, in Pediatric Associates of Lewiston P.A.'s judgment, is in your best interest to disclose to your family members and close friends who are involved in your health care.

4. **Uses and Disclosures of PHI Base Upon Your Written Authorization**

From time to time, you may request that Pediatric Associates of Lewiston P.A. disclose limited PHI to specified individuals or companies for a defined purpose and timeframe. These situations may include disclosures of sensitive PHI, such as HIV status or information about sexually-transmitted diseases, mental health or psychiatric treatment, or substance abuse services. Also, you may authorize disclosures to individuals who are not involved in treatment, payment, or health care operations, such as attorneys if you are involved in litigation either on your own or another's behalf. If you wish us to make disclosures in these situations, we will ask you to sign our "Authorization to Use and Disclose Protected Health Information."

5. **Uses and Disclosures of PHI that are Permitted or Required by Law**

In some circumstances, we may use or disclose your PHI without your consent or authorization. State and federal privacy law permit or require such use or disclosure regardless of your consent or authorization because it is in the best interest of our society at large that the use or disclosure of PHI be made in these situations.

- **Emergencies.** If you are incapacitated and require emergency medical treatment, we will use and disclose your PHI to ensure you receive the necessary medical services. We will attempt to obtain your consent as soon as practical following your treatment.
- **Communication Barriers**. If we try but cannot obtain your consent to use or disclose your PHI because of substantial communication barriers and your physician, using his or her professional judgment, infers that you consent to the use or disclosure, Pediatric Associates of Lewiston P.A. will make the use or disclosure.
- **Required by law**. We may disclose PHI to the extent required by law and in a manner limited to the specific requirement of the law.
- **Public Health Activities**. We may disclose your PHI to an authorized public health authority to prevent or control disease, injury, or disability, or to comply with state child or adult abuse or neglect law.
- **Health oversight activities**. We may disclose your PHI to a health oversight agency for audits, investigations, inspections, and other activities necessary for the appropriate oversight of the health care system and the government benefit programs such as Medicaid and Medicare.
- **Judicial and administrative proceedings**. We may disclose your PHI in the course of any judicial or administrative proceeding in response to an order expressly directing disclosure and within certain limits in response to a subpoena, discovery request, or other lawful process.
- **Law enforcement activities.** We may disclose your PHI to a law enforcement officer for law enforcement purposes.
- **Coroners, medical examiners, and funeral directors**. We may disclose your PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other lawful duties. We also may disclose you PHI to enable a funeral director to carry out his or her lawful duties.
- **Research**. We may disclose your PHI for certain medical or scientific research where the researchers have a protocol to ensure the privacy of your PHI.
- **Serious threats to health or safety**. We may disclose your PHI to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Armed forces personnel and national security**. We may disclose the PHI of members of the armed forces for activities deemed necessary by appropriate military command authorities to assure proper execution of the military mission. We also may disclose your PHI to certain federal officials for lawful intelligence, counterintelligence, and other national security activities.
- **Workers' Compensation**. We may disclose your PHI as authorized by and to the extent necessary to comply with the Maine Workers' Compensation Act or other similar programs that provide benefits for work-related injuries or illness without regard to fault.

- **You and DHHS**. We must disclose your PHI to you upon request and to the Secretary of the U.S. Department of Health and Human Services to investigate or determine Pediatric Associates of Lewiston P.A.'s compliance with the privacy laws.

6. **Your Rights Regarding PHI**

- Right to request restriction of uses and disclosures. You have the right to request that we not use or disclose any part of your PHI unless it is a use or disclosure required by law. Please advise us of the specific PHI you wish restricted and the individual(s) who should not receive the restricted PHI. We are not required to agree to your restriction request, but if we do agree to the request, we will not use or disclose the restricted PHI unless it is necessary for emergency treatment. In that case, we will ask that the recipient not further use or disclose the restricted PHI.
  •**Right of access to PHI**. You have the right to inspect and obtain a copy of your PHI in a "designated record set" (your medical and billing records) as long as we maintain the PHI in such format. However, you do not have a right of access to psychotherapy notes or information compiled in reasonable anticipation of a civil, criminal, or administrative proceeding. Also, your right of access may be limited if providing certain PHI to you may endanger the health or safety of yourself or others. To request access to your PHI, please make your request in writing to our Privacy Contact. We will respond to your request as soon as possible, but no later than 30 days from the date of your request. We have the right to charge a reasonable fee for providing copies of your PHI.
- **Right to confidential communications**. You have the right to reasonable accommodation of a request to receive communication of PHI by alternative means or at alternative locations. Please make your request in writing to our Privacy Contact. We will not require an explanation of your reasons for the request, but we will ask that you specify the alternative address or other method of contact and that you inform us of how payment for our medical services will be handled.
- **Right to amend PHI**. You have the right to request that we amend the PHI in your "designated record set" for as long as we maintain the PHI in such format. Please make your request in writing to our Privacy Contact. We will respond to your request as soon as possible, but no later than 60 days from the date of your request. If we deny your request for amendment, you have right to submit a written statement of reasonable length disagreeing with the denial and we have the right to submit a rebuttal statement. A record of any disagreement about amendment will become part of your medical records and may be included in subsequent disclosure of your PHI.
- **Right to accounting of disclosures**. Subject to certain limitations, you have the right to a written accounting of disclosure by us of your PHI for not more than 6 years prior to the date of your request. Your right to an accounting applies to disclosures other than those for treatment, payment, or health care operations; to yourself for a facility directory; to your family or close friends involved in your care; or for notification purposes. Please make your request in writing to our Privacy Contact. We will respond to your request as soon as possible, but not later than 60 days from the date of your request. We will provide you with one accounting every 12 months free of charge. We will charge a reasonable fee base upon our costs for any subsequent accounting requests.
- **Right to Notification of a Breach of Unsecured PHI.** You have a right to notification of a breach of your unsecured PHI held by us. Following the discovery of a breach, we will notify you of that breach in writing by first-class mail to your last known address as soon as possible, but in no case later than 60 calendar days after discovery of that breach. In urgent situations where we believe there is a risk of imminent misuse of unsecured PHI, we will contact you by the fastest means possible, such as telephone. In some situations, we may also provide notification of a breach to the media and, or to the Secretary of the U.S. Department of Health and Human Services.
- **Right to a copy of our Notice of Privacy Practices.** We will ask you to sign a written acknowledgement of receipt of our Notice of Privacy Practices. We may periodically amend this Notice of Privacy Practices and you may obtain an updated Notice from our Privacy Contact at any time.

7. **Complaint Procedure**

- **Within the Practice**. If you have a complaint about the denial of any of the specific rights listed in Section 6 above, about our Notice of Privacy Practices, or about our compliance with state and federal privacy law, please make your complaint in writing within the timeframes listed in Section 6 above or in any case within 60 days of the date of your complaint.
- **Outside of the practice**. If you believe that we are not complying with our legal obligations to protect the privacy of your PHI, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services. You must make your complaint to the Secretary in writing within 180 days of the act or omission forming the basis of your complaint.

(Revised 3/4/2013)

Written Acknowledgement Form
Receipt of Notice of Privacy Practices

Date of Implementation 4/15/03

I acknowledge that I was provided with the Notice of Privacy Practices of Pediatric Associates of Lewiston P.A.

Patient:
DOB:

*Signature of Parent/Legal Guardian________________________________

Relationship to Child____

Signature of Witness ____Date: 07/12/2016

For 18 years of age or older

Signature of Patient ____Date: 07/12/2016

Patient's DOB:

If the patient refuses to sign this acknowledgement, indicate your attempt to obtain a signature below.

[ ] Patient refused to sign this acknowledgment,
Date: _________________________
Time: _________________________

Reason for not obtaining the acknowledgement: _________________________
Employee Name: ____

Pediatric Associates of Lewiston P.A.

Patient Information

Patient Name:	**Date of Birth**:
Address:	
City, State, Zip:	
Home Phone:	
Ethnicity: Hispanic/Latino or Non Hispanic/Latino	**Race:**

Legal Guardian Information-PLEASE LIST BOTH GUARDIANS

Name: **Relationship to child:** **Gender: M or F**	**Date of Birth:**
Address:	**SSN:**
City, State, Zip:	
Home Phone:	**Cell Phone:**
Employer:	**Work Phone:**
E-mail Address: **(For future appointment reminders and statements)**	

Legal Guardian Information-PLEASE LIST BOTH GUARDIANS

Name: **Relationship to child:** **Gender: M or F**	**Date of Birth:**
Address:	**SSN:**
City, State, Zip:	
Home Phone:	**Cell Phone:**
Employer:	**Work Phone:**
E-mail Address: **(For future appointment reminders and statements)**	

Insurance Information

Primary Insurance:	
Address:	
City, State, Zip:	
Certificate #:	Group #:
Subscriber:	

Secondary Insurance:	
Address:	
City, State, Zip:	
Certificate:	Group #:
Subscriber:	

1. I certify that to the best of my knowledge the above information is correct.
2. I authorize Pediatric Associates of Lewiston P.A. to review my insurance coverage and to release any information pertinent to the processing of claims for services rendered to me.
3. I permit a copy of this authorization to be used in place of the original.
4. I hereby authorize you to pay directly to Pediatric Associates of Lewiston, P.A. benefits due to me out of my indemnity under the terms of my policy issued by your company.
5. I authorize Pediatric Associates of Lewiston, P.A. to release copies of my medical records to other medical providers who I maybe referred to, to further my care.

Signature of Guardian: ___________________________________ Print Name: _______________________

Relationship to child: ____________________________________

Date: 07/12/16

Pediatric Associates of Lewiston P.A.

Financial Policy

Patient Name:
Date of Birth:

Thank you for choosing Pediatric Associates of Lewiston as the health care provider for your children. We are committed to the care and treatment of your children. This financial policy is an important part of your child's care. Due to increased insurance company demands we ask you to read and agree to the following policy.

We accept a wide range of insurance plans. However, all policies have different benefits, and we cannot know the specific details of each individual policy. It is ***your responsibility*** to know your individual policy and to verify all benefits and coverage information prior to having any services rendered. Also, you must notify us of any changes to your insurance plan or policy prior to your visit.

Co-payments
All ***co-payments must be paid at the time of service*** as required by your insurance contract. If you are unable to pay your co-payment at check-in, an envelope will be provided to you for remittance of your co-payment to Pediatric Associates within 48 hours. A ***$10.00 late fee*** will be added to your statement if payment is not received within 48 hours of the date of service.

We accept cash, checks, visa, mastercard and discover.

You will be responsible for payment for the following reasons:

1. You do not have insurance (please ask about our "Pay in Full Discount Plan").
2. You are insured by a company or a member of a plan with which Pediatric Associates of Lewiston P.A. is not contracted.
3. Your child receives a service that is not covered by your policy. For example, some plans do not cover certain immunizations.
4. Your insurance company denies your claim for any reason that is not resolvable.
5. You cannot verify that you have insurance at the time of your appointment.

A $25.00 fee will be applied to your account for all returned checks.

Timely Payment
Any ***outstanding balance*** is required to be paid ***before your next office visit***. If the balance is not paid or reasonable payment arrangements are not made within 90 days, your account will be turned over to our collection agency. **<u>Furthermore, Pediatric Associates may dismiss you from the practice</u>.**

Missed Appointments
Pediatric Associates ***requires a 24 hour notice*** to cancel an appointment. If you miss three appointments without prior notification to our office, you may be dismissed from our practice.

Questions about this policy? Call Lynn, the Billing Manager at 207-784-5782.

I have read and agree to Pediatric Associate's Financial Policy.

__________________________________ ______________________________ Date: 07/12/2016
Signature of Patient or Responsible Party Print Name

Pediatric Associates of Lewiston P.A.

General Consent to Treatment

Patient Name:
Date of Birth:

General consent to treatment: By signing below, I, (or my authorized representative on my behalf) authorize Pediatric Associates and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my/my child's health, and to assess, diagnose and treat my/my child's illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associates with these options as well as alternative courses of treatment.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

____
Signature of Patient of Responsible Party

____
Print Name

____
Relationship to Patient

Date: 07/12/2016

Release Form for individuals involved in care of patient

I, _______________________________, give Pediatrics Associates of Lewiston P.A. permission to speak with the following people regarding my child's health status, including diagnosis, treatment options and plans and payment for health services I receive from Pediatrics Associates of Lewiston P.A.

This consent is valid until such time as I provide Pediatrics Associates of Lewiston P.A. written revocation of it.

Patient Name:
DOB:

Pediatrics Associates of Lewiston, P.A. may speak with:

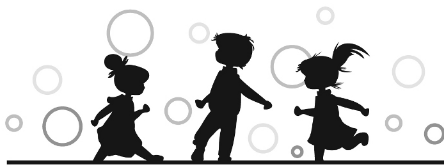
Name ________________________________ DOB:__________
Address: ____
Phone:________________Relationship:____________________

Name: _______________________________ DOB:__________
Address:____
Phone:_________________Relationship:____________________

Name: _______________________________ DOB:___________
Address:____
Phone:__________________Relationship:__________________

Patient/Guardian Signature: _____________________________________
Print Name:______________________________________
Relationship to Patient:______________________________

Date: 07/12/2016



Pediatric Associates
of Lewiston

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

This authorization is for the use or disclosure of protected health information pertaining to:

Patient Name: ____

Address:____

DOB : ____________________ Phone: _______________________

I hereby authorize the following health care provider:

Name: ____

Address: ____

To *release* my protected health information to:

Name: ____

Address: ____

Purpose of disclosure:

€ Changing Physicians (reason for transfer) ____

€ Legal Other ____

Protected health information to be released:

€ Medical records (specify, or can state "all"): ____

€ Billing records

Time frame: €entire record €records from __________ (date) to ___________ (date)

CONFIDENTIAL INFORMATION

Your specific permission is required to disclose information regarding the following:

I do ____(initials) I do not : authorize the release of Treatment by Mental Health Professional or Program

I do____ (initials) I do not : authorize the release of Drug/Alcohol Abuse

I do ____(initials) I do not : authorize the release of HIV Test Results or Status

I do ____(initials) I do not : authorize the release of Domestic Violence or Sexual Assault

I do ____(initials) I do not : authorize the release of Genetic Testing Results

(Maine law requires our practice to inform you that disclosing your HIV infection status may have consequences, such as negative treatment in your personal life, at work or by insurance companies, if this information is misused. It can be important for providing you needed services & healthcare.)

- Continued -

My Rights:

- I understand that I am not required to sign this form and **Pediatric Associates of Lewiston** will not condition treatment, payment of services, or eligibility for services on whether I sign this form. I understand that my refusal to sign may result in improper diagnosis or treatment, denial of coverage for health benefits or other insurance or other adverse consequences.

- I understand that PHI released pursuant to this authorization may include records generated by another healthcare provider or facility.

- I understand that I have the right to access or copy the PHI described in this form by making a written request to the **Privacy Officer** of this practice: **Celina Gauthier/ 33 Mollison Way, Lewiston ME 04240 207-784-5782**. A copying fee may be charged as permitted by law.

- I understand that I have the right to withdraw my authorization at any time except to the extent that action has been taken on reliance on this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer at **Pediatric Associates of Lewiston**. I understand that revocation may be the basis for denial of health benefits or other insurance coverage or benefits.

- I understand the PHI used or disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer be protected by confidentiality laws.

- I understand that PHI that includes alcohol or drug program information protected by federal law will require notice to the person receiving the information that it may not be shown to or shared with others without my express written permission.

- I understand that I have a right to receive a copy of this authorization.

Expiration: This authorization becomes effective immediately and shall expire on: ______________.
If no date is given this authorization is valid for **<u>30 months</u>** from signature date.

Signed: ____ **Date:** _________________

Print name: ____

Relationship to Patient: __________________________________

Witness Signature: ____

Rev. March 2015