Pediatric Associates
of Lewiston

This notice describes how your medical information as a patient of this practice may be used and disclosed and how you can get access to this information. Please review it carefully.

Each time you visit us, we keep a record of your care and treatment. We take the protection of your personal information seriously. We are required to provide you with this Notice of Privacy Practices to tell you about our legal duties and ways we may use and share your information, and to inform you about your rights regarding your health information. We give a small number of examples to describe what the categories mean, but not every use or disclosure can be listed on this Notice.

You have a right to a paper copy of this Notice of Privacy Practices.

This Notice is effective as of: January 1, 2018. We will ask you to sign a written acknowledgment of receipt of our Notice. We reserve the right to change the terms of this Notice and post the current Notice in our office. You may obtain an updated Notice from our practice at any time.

If you have any questions about this Notice of Privacy Practices, please contact: *Pediatric Associates of Lewiston P.A, 33 Mollison Way, Lewiston, ME 04240, (207) 784-5782 Contact Person: Celina Gauthier, Privacy Officer*

How We May Use and Disclose Protected Health Information

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. When possible, this practice sends patient health information electronically using a Health Information Systems Program that is compatible with Allscripts Professional Direct Messaging.

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.

For our Healthcare or Business 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. 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.

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.

Immunization Registry We participate in a state-wide immunization registry called Immpact2. This means that your immunization information, maintained electronically, and may be shared with other doctors and hospitals that care for you.

Workplace Monitoring Pediatric Associates management team may listen to employee phone conversations with parents of patients and/or patients of this practice. Calls will be monitored for training purposes to critique skills.

When Allowed by Law: The law allows us to use or disclose your protected health information in certain situations, including:

- when required for public health purposes
- when any school requests information on a student's immunization status
- Reporting child abuse/neglect

With your Authorization: Other uses and disclosures will be made only with your written authorization. For example, we will ask for your written permission before promoting a product or service to you for which we will be paid by a company, and generally before sharing your health information in a way that is considered a sale under the law. If you sign an authorization, you may revoke it at any time, except where we have already shared your information based upon your permission.

Minors

For divorced or separated parents: each parent has equal access to health information about their unemancipated child(ren), unless there is a court order to the contrary that is known to us or unless it is a type of treatment or service where parental rights are restricted.

Rights That You Have

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 based 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.

Complaint Procedure

Within the Practice. If you have a complaint about the denial of any of the specific rights listed in the "Rights that You Have Section" 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 this section 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.

Pediatric Associates
of Lewiston
Serving the Community Over 50 Years!

NO SHOW POLICY

We schedule patient appointments so that each patient receives the right amount of time to be seen by our providers and staff. That's why it is very important that you keep your scheduled appointment with us, and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Pediatric Associates of Lewiston sends text messages and email reminders 1 week, 2 days, and 2 hours in advance of the appointment time. If your schedule changes and you cannot keep your appointment, please notify this practice in advance by texting or calling (207) 784-5782.

If a notice is not provided that an appointment needs to be canceled or rescheduled, our office determines that the appointment is a ***"No-Show".*** The parent or patient failed to provide notification and failed to arrive to the appointment.
If a family and/or patient no-shows a total of 5 appointments within a 12 month period, Pediatric Associates reserves the right to dismiss the family and/or patient from the practice. The guarantor listed on the account will receive a Dismissal Letter in the mail for each patient listed on the account. As a courtesy, Pediatric Associates staff will be available to treat the child(ren) listed on the account for 30 days on an emergency basis only. During this time, the parent/guardian needs to be proactive and find another healthcare provider for their child(ren). After 30 days has passed, the patient's and siblings' charts will be marked as inactive and they will no longer be able to receive healthcare services from anyone at Pediatric Associates of Lewiston.

Acknowledgement of Receipt of Privacy Notice

I acknowledge that I was provided with a copy of Pediatric Associates of Lewiston, P.A.'s Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state law.

Date of Implementation 01/01/2018

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_____Date: _____

Print Parent/Legal Guardian Name_____

Relationship of Parent/Legal Guardian_____

Signature of Witness _____Date: _____

For patient's 18 years of age or older

Signature of Patient _____Date: _____

Patient's DOB: 09/06/2017

Signature of Witness _____Date: _____

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: _____

Patient Information

Patient Name:	**Date of Birth**:
Address:	
City, State, Zip:	
Home Phone:	
Ethnicity:	**Race:** Refused to Report
Cultural Identity:	

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: Claims	
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 Patient's Responsible Party:_____PrintName:_____

Relationship to child:_____
Date: _____

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Serving the Community Over 50 Years!

Authorization – Non-Parent/Guardian to Accompany Patient

Patient Name:
DOB:

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances; however, we must have a written authorization letter allowing this person to accompany your child.

This authorization gives the person permission to contact the office for medical advice, schedule appointments, bring your child in, speak to the doctor, give authorization for treatment, vaccinations, medications, procedures and make general health decisions.

I, _____, give the person listed below permission to bring my child to Pediatric Associates of Lewiston, PA and to discuss and share medical information about my child. I further authorize them to see all necessary medical records and make health care decisions of a routine nature as determined at the sole discretion of the Pediatric Associates of Lewiston provider.

I also give them authority to make more serious or urgent health care decisions in the event I cannot be reached or where it is of an emergency nature where there is not sufficient time to seek out my specific consent.

_____ _____
Name of Person (allowed to bring child) Relationship to Patient

_____ _____
Name of Person (allowed to bring child) Relationship to Patient

_____ _____
Name of Person (allowed to bring child) Relationship to Patient

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

Pediatric Associates
of Lewiston

Financial Policy

Patient Name:
Patient 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.
Health Insurance policies are complex. There are many different types of insurances available. It is important that you understand your insurance plan and our financial policies as well. Since it is our primary goal to provide the best healthcare for your children, we provide and offer a variety of services in our office. These services include a variety of labs, tests, and procedures. Some of these services have additional charges associated with them. Most are recognized by insurance companies. However, you may be required to pay additional amounts for these services depending on the type of insurance plan you have and your coverage. This office accepts patients who have private insurance, Maine Care and those who are uninsured. **It is always your responsibility to notify us immediately of any changes made to the above-named patient's coverage.**

Newborn Coverage
Newborn babies need to be added to your insurance plan within 30 days of birth to ensure coverage. We understand that it takes time to get added to the plan and receive an insurance card. When you receive your newborn's insurance information or card, please contact us as soon as possible with this information.

Co-Payments and Deductibles
Contracting with health insurance companies requires us to collect co-pays and deductibles.
Your co-pay is due at the time of service regardless of who brings in the child for the appointment.
If the patient has not met their deductible, Pediatric Associates will require payment at the time of the visit.
We accept cash, checks, Visa, Mastercard, Discover, and Care Credit.
A $25.00 fee will be applied to your account for all returned checks.

Self-pay Accounts
Self-pay accounts are patients without insurance coverage, patients who have a balance due after their insurance has processed a claim, patients covered by insurance plans in which our practice does not participate, or patients without an insurance card on file with us. It is always the patients' responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven.

Patients with no insurance coverage will be required to pay a minimum payment of $95 at the appointment (walk-in and scheduled) and will be asked to make payment arrangements for the balance.

Patients with no insurance coverage who schedule appointments with Dr. Hamilton must pay a minimum payment of $250 at the time of the appointment. In addition, payment arrangements for the balance due will also be required. Payment arrangements are available if needed. Please ask to speak with our Billing Manager to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Nonpayment
If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we will restrict/cancel any requested or scheduled appointments for your child(ren), and your child(ren) may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Missed Appointments Pediatric Associates requires a 24-hour notice to cancel an appointment. If you miss 5 appointments without prior notification to our office, you will 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: _____
Signature of Parent/Legal Guardian

General Consent to Treatment

Patient Name:
Patient 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 healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options, the common risks, anticipated burdens/benefits associated with these options, and 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 health care provider. 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 or Responsible Party Date: _____

_____
Print Name

_____
Relationship to Patient

HealthInfoNet

Opt-out Form

(to **not** share general health information)

If you want to share your health information through HealthInfoNet, you do not need to do anything with this form.

What is HealthInfoNet?
HealthInfoNet is a secure computer system that brings your health information from different healthcare providers into one statewide electronic health record. **Your providers use this information to make better decisions about your care**. It can also help them prevent mistakes, especially in an emergency. Your health record includes information about your medicines, allergies, test results, and more.

Are my records private and secure?
HealthInfoNet encrypts all information and sends it over secure computer connections**.** Only those involved in your care can look at your information. To find out who has looked at your record and when they looked at it, go to www.hinfonet.org/audit. Of course, no system is completely secure, but HeathInfoNet makes every effort to keep your records safe.

What does it mean to "opt-out"?
If you do not want your health information in a HealthInfoNet record, fill out this form to "opt-out", or not share your health information. Your choice to opt-out will not affect your ability to get medical care. If you decide later that you want to have a HealthInfoNet record, you will need to call HealthInfoNet or fill out an "opt-in" form on the HealthInfoNet website at www.hinfonet.org/yourchoices

I choose not to share my health information

Fill out this form and mail it to HealthInfoNet, 60 Pineland Drive, Portland Hall, Suite 230, New Gloucester, ME or fax it to 1-207-541-9258, Or fill this form out online at www.hinfonet.org/yourchoices
If you have questions, call HealthInfoNet at 1-866-592-4352 or 207-541-9250, or email us at info@hinfonet.org.

Patient Name:

Address:

Sex: Date of Birth: __ __ __ – __ __ – __ __ __ __
Social Security Number (not required)

Phone Number: Email:

By signing, I understand that my health information will not be available to providers using HealthInfoNet, even in an emergency.

_____ _____ / ____ / _____
Signature of Patient or Guardian **Date** (month / day / year)

Pediatric Associates
of Lewiston

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

This authorization is for the use or disclosure of 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: Pediatric Associates of Lewiston, PA
Address: 33 Mollison Way Lewiston, ME 04240
Phone: (207) 784-5782 Fax: (207) 783-9268

Purpose of disclosure:

- □ Changing Physicians (reason for transfer) _____
- □ Legal □ Other _____

Information to be released:

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/□ I do not ____ (initials): authorize the release of Treatment by Mental Health Professional or Program
□ I do/□ I do not ____ (initials): authorize the release of Drug/Alcohol Abuse
□ I do/□ I do not ____ (initials): authorize the release of HIV Test Results or Status
□ I do/□ I do not ____ (initials): authorize the release of Domestic Violence or Sexual Assault
□ I do/□ I do not ____ (initials): 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.)

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 **30 months** from signature date.

Signed: _____ **Date:** 07/19/2021

Print name: _____

Relationship to Patient: _____

Witness Signature: _____

Rev. February 2020