Financial Policy

In order to better serve your needs and clarify any questions that you may have regarding your insurance, we have adopted the following financial policy. If you have any questions please speak to the billing staff and they will gladly assist you.

1. We will gladly file your insurance if our office participates with your individual insurance plan. At the time of service you will be responsible for any co-pays, deductibles and any co-insurance amounts. Our staff will gladly tell you if we participate with your plan.

2. We must have a copy of your insurance card to file any insurance for you or your family member at each visit. If you have multiple insurance's you must present all cards. Failure to present cards may result in you being billed for any charges incurred or you may be asked to reschedule the visit.

3. All charges for services incurred with our office will become due and payable 30 days from the date of service. This will allow sufficient time to process the insurance claim and for you to make payment in full of any balance remaining applicable to deductibles or co-insurance amounts. If we have not received payment from your insurance company, the total balance due becomes your responsibility.

4. Our office will complete insurance claim forms for services rendered with your primary insurance carrier. As a courtesy to you, we will also file your secondary insurance. You will be responsible for filing with your tertiary plan for reimbursement. If we do not participate with your insurance company, we will, upon request, furnish you with a claim form that you can submit to your carrier for payment reimbursement as payment is due by this office at the time of service. Please be advised that you may not be reimbursed by your insurance if this office is a non-participating provider for your plan or your insurance company. In the event of duplicate payment by the insurance carrier and the patient, the overpayment will be refunded on a quarterly basis only. For those patients wanting Faith Pediatrics to re-file their claims after 3rd resubmission, there may be a $5.00 service charge.

5. We strongly encourage you to contact your insurance carrier if you have not received any explanation from them within 30 days as to why your claim is pending, denied, or when your explanation (EOB) is forthcoming.
6.For those patients who are members of HMO or PPO insurance products please verify with the receptionist before your visit that you do have Faith Pediatrics or one of its physicians listed as you primary care provider in order to be seen. If this facility or one of its physicians is not listed as primary care provider you will be responsible for your charges on the date of service or you may be asked to reschedule.

7. All insurance changes must be given to us at the time of service. If your insurance changes and we are not notified, you will be responsible for all charges incurred and we will be unable to bill your insurance for any prior charges before the change notification.

8. The responsibility for payment for services rendered to any children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of our office. You will be expected to pay any co-pays, deductibles, etc. at the time of the visit.

9. The responsibility for services rendered to dependent children for accidents, motor vehicle accidents, etc., rest solely with parents who seek treatment. We will gladly bill your insurance company for charges incurred or provide parent with proof of private payment for such services. We do not bill attorney offices or any third parties unless legally required to do so. These visits remain the responsibility of parent seeking treatment.

10. Collection policy for Faith Pediatrics allows patients sufficient opportunity to pay for all charges incurred

in a reasonable and timely manner. However, once the account has been turned over to our collection agency, this office will no longer accept any payments. You must contact our collection agency to arrange payment for amounts placed with our collection agency.

11. Payment plans can be made available for families at the discretion of management unless collection processes have began on unpaid accounts. You account can be turned over for collections on the 31st day after the date of service per this financial policy.

12. In the event your health insurance plan determines a service to be "not covered," you will be responsible for this charge.

13. There will be a $50.00 charge assessed to your account for all appointments that are missed or not canceled within 24 hours for established patients. This fee is due and payable upon next date of service and is subject to collection proceedings. There is also a $50.00 new patient missed appointment fee. Telecheck charges a $35.00 service charge for all returned checks.
14. You are responsible for the charges in our office. Any supplies that you receive from our office must be paid in full at the time of service. Insurance companies do not cover miscellaneous supplies so these costs are the patient's responsibility.
15.Financial responsibility lies between you and your insurance company. It is your responsibility to ensure your insurance pays accordingly. We will, of course, gladly assist you in any way possible with your insurance concerns and problems.

Authorization:
I agree to be responsible for my child's medical expenses; therefore, I authorize my insurance company, attorney, and any other parties to pay directly to Faith Pediatrics, and/or provide any information regarding payment of my bill, and agree to the financial policy stated above and I accept responsibility for any balances not covered by my medical insurance company.

Signature: _____ Date:_____

It is our hope that the above financial policy will allow us to provide quality care to our patients. If you have any questions or need clarification of any of the above policies, please do not hesitate to speak with someone in our office.

Notice Of Privacy Practices
As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

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

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

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

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

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

Privacy Officer, 3350 Six Forks Road, Raleigh, NC 27609, 919.881.9440

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI.

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

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

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

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

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

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

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

9. Special Provisions for Minors under North Carolina Law: Under North Carolina law, minors with, or without the consent of a parent or guardian have the right to consent to services for the prevention, diagnosis, and treatment of certain illnesses including: venereal disease and other diseases that must be reported to the State; pregnancy; abuse of controlled substances or alcohol; and emotional disturbance. Regarding abortion services, however North Carolina law requires the consent of both, the minor and the parent, guardian, or a grandparent with whom the minor has been living for at least six (6) months, unless a court has determined that a minor alone can consent to the abortion. If you are a minor and you consent to one of these services, you have all the authority and rights included in this Notice related to that service. In addition, the law permits certain minors to be treated as adults for all purposes. These minors have all rights and authority included in this Notice for all services.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

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

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

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

2. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities

authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, license and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

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

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

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

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

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

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

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

9. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to: Privacy Officer, 3350 Six Forks Road, Raleigh, NC 27609, 919.881.9440 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate

reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to Privacy Officer, 3350 Six Forks Road, Raleigh, NC 27609, 919.881.9440.Your request must describe in a clear and concise fashion:

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

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Privacy Officer, 3350 Six Forks Road, Raleigh, NC 27609 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Privacy Officer, 919.881.9440 for further information. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department uses your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to [Privacy Officer at 919.881.9440, for further information]. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact our Privacy Officer at 919.881.9440 for further information.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint

with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Privacy Officer at 919.881.9440 who is responsible for handling complaints. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

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

Again, if you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer at 919.881.9440.

Faith Pediatrics and Adolescent Medicine, Inc.

Receipt of Notice of Privacy Practices
Written Acknowledgement Form.

I, _____, have received a copy of Faith Pediatrics and
(Parent name)

Adolescent Medicine Inc.'s Notice of Privacy Practices on behalf of _____.
(Patient name)

_____ _____
Signature of Patient/Guardian Date

DECLINATION OF NOTICE OF PRIVACY PRACTICES
WRITTEN DOCUMENTATION FORM

Patient/guardian has declined to sign the acknowledgement form to indicate that a copy of Notice of Privacy Practices has been given to them due to _____.

_____ _____
Name of Patient Staff Signature

SUBMIT FORM