Patient Rights & Responsibilities

As a patient at Practical Approach Pediatrics and Pediatric Dentistry, you have the right:

- To be treated with courtesy and respect.
- To have your privacy protected and to receive our Notice of Privacy Practices.
- To have your questions answered promptly.
- To know the name, role and qualifications of your child's caregiver.
- To know what services are available, including translators.
- To know what rules apply to you.
- To have information about your child's diagnosis, choices, risks and benefits of treatment so you can assist in developing a plan of care, including the management of pain.
- To refuse treatment except as otherwise provided by law.
- To be given, on request, information and counseling on available financial resources.
- To know, on request and before treatment, whether Medicare assignment is accepted.
- To receive, on request and prior to treatment, a reasonable estimate of charges for medical care and, on request, an itemized bill with charges explained.
- To receive medical treatment regardless of race, national origin, religion, physical handicaps, or sources of payment and to expect appropriate management of pain.
- To receive treatment for any emergency medical condition that may get worse if not treated.
- To know if medical treatment is for research and to either consent or refuse.
- To have the right to make Advance Directives.
- To be free from restraint and seclusion which are not medically necessary.
- To the confidentiality of your medical record and the right to access information from it.
- To have a family member or representative and your physician notified promptly of admission to the hospital.

As a patient at Practical Approach Pediatrics and Pediatric Dentistry, you are responsible:

- To give the health care provider correct and complete information about your child's present medical condition, past illnesses, hospitalizations, medications, including over-the-counter drugs/herbal supplements, and other health matters.
- To report changes in your child's condition and report perceived safety concerns in their care.
- To tell your health care provider if you understand the plan of treatment and what is expected of you, including pain relief options and ask questions if you do not understand.
- To follow the treatment plan recommended by your health care provider.
- To keep appointments or notify the health care provider or facility if you cannot.
- To accept responsibility for your actions if you refuse treatment or do not follow the health care provider's instructions.
- To meet your health care financial obligations promptly.
- To follow rules and regulations on patient care.
- To respect office personnel and property.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about your child may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by law to provide you with this notice that explains our privacy practices with regard to your child's medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

Ways in Which We May Use and Disclose Your Protected Health Information

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician whom we have requested to be involved in your care. *For example* – we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Payment. We will use and disclose your protected health information to obtain payment for the health care services we provide you. *For example* – we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations. We will use and disclose your protected health information to support the business activities or our practice. *For example* – we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription services for our practice.

Other Ways We May Use and Disclose Your Protected Health Information:

Appointment Reminders. We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.

Treatment Alternatives. We will use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

Others Involved in Your Care. We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

Research.. We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

To Avert a Serious Threat to Public Health or Safety. We will use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Worker's Compensation. We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates. We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with healthcare, to protect the health and safety of others, or for the safety and security of the correctional institution.

Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

A Paper Copy of This Notice. You have the right to receive a paper copy of this notice on request. You may obtain a copy by asking our practice manager at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy. You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psycho-therapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our practice manager, Practical Approach Pediatrics and Pediatric Dentistry, 9480 Huebner Road, Suite 400, San Antonio, TX 78240. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

Request Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and the reasoning that supports your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

- the information was not created by us, or the person who created it is no longer available to make the amendment;
- the information is not part of the record which you are permitted to inspect and copy;
- the information is not part of the designated record set kept by this practice; or if it is the opinion of the health care provider that
- the information is accurate and complete.

Request Restrictions. You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations. *For example* – you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our practice manager.

We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your request unless that information is needed for emergency treatment.

An Accounting of Disclosures. You have the right to request a list of the disclosures of your health information we have made outside of your practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) nor for a period of time greater than six years (our legal obligation to retain information).

Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12 months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with your to preserve your privacy. *For example* – you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

File a complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice manager or directly to the Secretary of Health and Human Services.

To file a complaint with our manager, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to Practical Approach Pediatrics and Pediatric Dentistry, 9480 Huebner Road, Suite 400, San Antonio, TX 78240. You should know that there would be no retaliation for your filing a complaint.

Uses or Disclosures Not Covered

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about your for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

For More Information

If you have questions or would like additional information, you may contact our practice manager at **210-697-3900**.

Office Policies

- Regular office hours are Monday through Friday, 8:00am to 5:00 p.m. Extended hours are available by appointment only.
- As a courtesy to our patients, we make every effort to call and remind you about your child's upcoming appointment. If you are ever in doubt of your appointment time please do not hesitate calling our office.
- Please allow 5 working days for copies of medical records including immunization records for school and/or day care. Please keep in mind there may be a fee for medical records.
- We will make every attempt to refill your prescriptions in a timely manner. However, please allow 48 hours for all medication refills to be called in to your pharmacy. Please have the pharmacy call, two days prior to the empty refill.

Patient Name:_____ Date of Birth_____

FINANCIAL POLICY

Thank you for choosing *Practical Approach Pediatrics and Pediatric Dentistry* as your healthcare provider. Our staff will be happy to discuss our fees and this policy with you at any time. Please read and sign this financial policy prior to seeing the physician.

1. Payment for services is due at the time services are rendered, including any portion of your balance that is not covered by your insurance. We accept cash, check, VISA, Master Card, AMEX and Discover.

2. Your insurance policy is a contract between you, your employer, and the insurance carrier. We are NOT a party to that contract. We will follow their guidelines for submission of claims, co-pay amounts, and reimbursements. Any contractual provider discounts will be deducted from your balance.

3. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies and some employers decide what is and what is not a covered benefit. Please check your insurance plan for any questions.

4. Co-Payments not paid at the time of service are subject to a **$10 processing fee.** All balances more than 60 days past due are subject to a penalty of **$10 per month** to cover the cost of sending additional statements.

5. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. **If your insurance company does not pay within 60 days, you will be responsible for payment.**

6. Returned checks and balances older than 90 days may be subject to collection placement and collection fees which will be charged to the responsible party. If we are forced to send your account to collections, a **40% fee will be added to your balance**. There will be a **$35 non sufficient funds (NSF)** charge on all returned checks.

7. Occasionally, an insurance payment results in overpayment on your account and generally this balance remains on your account as a credit for use at a future visit. **You may request a refund of overpayment by notifying the billing office.**

8. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to our billing office, so that we can assist you in management of your account with a payment plan.

9. Please note that all cancellations must be made at least 48 hours in advance. This allows us to care for other patients in need of our services. If you fail to cancel your appointment within 48 hours, you may be charged a $25 service fee.

10. In an effort to care for our patients in a timely manner, we ask that you show up on time for appointments. Otherwise, we may have to reschedule your child. If you are running late, call us ASAP so we can advice you on the earliest available new appointment time.

Again, thank you for choosing *Practical Approach Pediatrics and Pediatric Dentistry*. We appreciate the opportunity to serve you.

Guardian Name: _____ Signature: _____Date:_____

PHONE ADVICE

DURING OFFICE HOURS

Please feel free to call our office at **210.697.3900** to make an appointment or if you have any questions or concerns. Remember there is no “silly” question except the one not asked. We are here for our patients.