OFFICE POLICIES

RETURN CHECK POLICY
Please be advised that there is a $20 fee on individual returned checks. Fee of service and returned check fee will be due immediately upon returned check.

NO SHOW APPOINTMENT POLICY
A fee of $15 will be charged for no call/no show appointments. Please refer to full Appointment No Show Policy that was provided to you.

MEDICAL RECORDS REQUEST POLICY
All medical records request not being forward to another medical office will require a $5 fee at the time of request. A medical records release form must be signed by the responsible party and on file. Please allow 3 – 5 business days for processing.

PRIVATE PAY POLICY
Responsible party of private pay/self pay patient is responsible for $50 at check-in. The responsible party will need to pay 50% of the visit at check-out. The $50 is included with 50%.

CELL PHONE USE
Please refrain from using your cell phone while in the office. This is to ensure fluid communication between medical staff and parent/guardian/patient.

SPECIAL FORMS POLICY
All special case forms to be filled out by the physician require a flat fee of $10. Please allow 3 – 5 business days for completion. Our office will advise when forms are ready for pickup.

PRESCRIPTION REQUEST POLICY
Please allow 24 – 48 hours on all prescription refill requests. Controlled substances (i.e. ADHD prescriptions) need to be submitted through the Athena Patient Portal to the POMP medical staff. All other refill requests need to be submitted through the patient’s pharmacy. Our office will advise when prescription is ready.

Your cooperation is greatly appreciated. If you have any questions, please address them to the front office personnel.

Thank you,

Office Manager
**NO SHOW APPOINTMENT POLICY**

Peace of Mind Pediatrics welcomes patients from all walks of life. We strive to provide a professional and respectful service to all of our patients and parents/guardians. Our goal is to accommodate all of our patients with appointments whether they are scheduling in advance or requesting a same day appointment. We require at least 24 hours notice for all appointment cancellations and rescheduling. All no show appointments are logged into the patient’s medical records.

Although POMP strongly advises against no show appointments, we allow one no show per patient at no cost to the responsible party. Each no show there after requires a fee of $15 (patients filing SoonerCare excluded). Each patient is afforded 3 no shows before possible termination from POMP practice. This policy assists in ensuring the best care for all patients. A letter of notification regarding each no show appointment will be mailed to the responsible party.

Please be sure to sign and date this form confirming receipt of this policy. If you have any questions or concerns regarding the no show appointment policy, please address them to the office manager. Thank you for your cooperation. Thank you for choosing Peace of Mind Pediatrics for your child(ren)’s health care needs.

Patient Name ____________________________________________

Responsible Party Signature ____________________________________________

Date ______________________________
INSURANCE FILED BY THIS OFFICE IS DONE AS A COURTESY. HOWEVER, GUARDIAN IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS THE GUARDIAN’S RESPONSIBILITY TO BE AWARE OF BENEFITS THAT THEIR INSURANCE PROVIDES FOR VISITS. ALL INSURANCE CO-PAYS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE.

- I request that payment of authorized benefits be made to Peace of Mind Pediatrics, PLLC.
- I further authorize the release of any medical information necessary to process insurance claims or any medical information that is required for any healthcare related utilization review or quality assurance activities or any healthcare professional requiring this information.

This authorization will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

________________________________
Parent/Guardian                Date

______________________________
Relationship to patient

This is to acknowledge that I have received or seen a copy of the office’s Notice of Privacy Practices.

______________________________
Parent/Guardian Signature      Date
HIPAA Notice of Privacy Practices for Personal Health Information
Effective Date: August 1, 2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

We are required to provide you with this Notice of Privacy Practices and to explain our legal duties under the Federal Health Insurance Portability and Accountability Act (HIPAA).

By law, we are required to:
● maintain the privacy of your Personal Health Information (PHI)
● provide you this notice of our legal duties and privacy practices with respect to your PHI; and
● follow the terms of this notice.

How We Collect Information: We obtain most PHI directly from the Individual. The Information that an Individual gives us when registering for services generally provides the Information we need. An individual’s clinical information is forwarded directly to the individual and some form of record is either retained in secure hard copy file or with a laboratory’s archival record for 3 years. If we need to verify information or need additional Information, we may obtain information from third parties such as adult family members or employers. Information collected may relate to an individual’s demographics, employment, health, avocations or other personal characteristics which may assist us in evaluating the individual’s healthcare. In most cases we do not retain the dates and locations where service was provided.

We protect your PHI from inappropriate use or disclosure. Our employees, and those of companies that help us service your health screening, are required to comply with our requirements that protect the confidentiality of your PHI. They may look at your PHI only when there is appropriate reason to do so, such as to administer the process of returning your health test results back to you.

We will not knowingly disclose or sell your PHI to any other individual or organization, forward your PHI by mail, fax or electronically, or make available your test results to your employer or 3rd party carrier without your prior written consent.

We May Use and Disclose PHI about You without Your Authorization unless you Object as described below, together with some examples.
Appointments and Other Health Information. We may send you reminders for medical care or checkups. We may send you information about future health services that may be of interest to you as a health conscious individual.

Research: We may use PHI about you for studies and to develop reports. These reports do not identify specific people. For example, we may want to determine how many individuals of a sex in an age range from a defined population have a asthma.

Future Business: PHI may be disclosed as part of a potential merger or acquisition involving our business in order to make an informed decision regarding any such prospective transaction. Should a merger or acquisition take place, our database of names and addresses may be part of the process.

Where Required by Law or for Public Health Activities: We may disclose PHI when required by federal, state or local law. Examples of such mandatory disclosures include notifying state or local health authorities regarding particular communicable diseases, or providing PHI to a government agency or regulator with health care oversight responsibilities. We may also release PHI to a coroner or medical examiner to assist in identifying a diseased individual or to determine the cause of death.

For Payment. We may use or disclose PHI about you to get payment or to pay for health care services you receive. For example, we may provide PHI to bill your health plan for health care provided to you.

To Avert a Serious Threat to Health or Safety: We may disclose PHI about you to law enforcement in order to avoid a serious threat to the health and safety of a person or the public.

For Law Enforcement or Specific Government Functions: We may disclose PHI in response to a request by law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose PHI about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

When Requested as Part of a Regulatory or Legal Proceeding: If you or your estate is involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the PHI requested. We may also disclose PHI to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.

Other Uses of PHI: Other uses and disclosures of PHI not covered by this notice and permitted by the laws that apply to us will be made only with your written authorization or that of your
legal representative. If we are authorized to use or disclose PHI about you, you or your legally authorized representative may revoke that authorization, in writing, at any time. We cannot take back any uses or disclosures already made with your authorization.

• Disclosure to Family, Friends, and Others: We may disclose PHI about you to your family or other persons who are involved in your medical care.

• Directory. We may use PHI about you to assist visitors at our facilities to locate you or to inform clergy about you.

Your PHI Privacy Rights

• Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI. You must make the request in writing and include dates and location(s) of service. You may be charged a fee for the cost of copying and mailing the PHI to you.

• Right to Request to Correct or Update Your PHI. You may ask us to change or add missing PHI if you think there is a mistake. You must make the request in writing and provide a reason for your request. However, there are conditions under which we may deny this request.

• Right to Get a List of Disclosures. You have the right to ask us for a list of disclosures made after August 1, 2015. You must make the request in writing.

• Right to Request Limits on Uses or Disclosures of Your PHI. You have the right to ask us to limit how PHI about you is used or disclosed. You must make the request in writing and tell us what PHI you want to limit and to whom you want the limits to apply. In your request, you must you must tell us (1) dates and location(s) of service (2) what information you want to limit; (3) whether you want to limit our use, disclosure , or both; and (4) to whom you want the limits to apply (for example , disclosure to your spouse or parent). To make a request, you must make your request in writing to Office Manager, Peace of Mind Pediatrics, 5476 Main Street Suite 105, Del City, OK 73115. We will not agree to restrictions on PHI uses or disclosures that are legally required, or which are necessary to administer our business. While we will consider your request, we are not required to agree to it. If we do agree to it, we will comply with your request.

• Right to Revoke Permission. If you are asked to sign an authorization to use or disclose PHI about you, you can cancel that authorization at any time. You must make the request in writing. This will not affect PHI that has already been shared.
• Right To Choose How We Communicate With You. You have the right to ask us to share your PHI with you in a certain way or in a certain place. For example, you may ask us to send PHI about you to your work address instead of your home address. You must make this request in writing. You do not have to explain the basis for your request.

• Right to File a Complaint. You have the right to file a complaint if you do not agree with how we have used or disclosed PHI about you. All complaints must be submitted in writing. Your services will not be affected by any complaints you make. We cannot retaliate against you for filing a complaint or refusing to agree to something that you believe to be unlawful.

• Right to Get a Paper Copy of this Notice. You have the right to ask for a paper copy of this notice at any time. ADDITIONAL INFORMATION We reserve the right to change the terms of this Notice of Privacy Practices at any time. Any changes will apply to information we already have and any information we receive in the future. A copy of the new notice will be provided to individuals upon request as required by law. You may request a copy of the current notice at anytime

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office, or going to our Website.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient/Guardian understands that:

• Protected health information may be disclosed or used for treatment, payment or health care operations.
• The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
• The Practice reserves the right to change the Notice of Privacy Policies.
• The Patient has the right to restrict the uses of their information.
The Patient/guardian may revoke this Consent in writing at any time and all future disclosures will then cease.

The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient’s behalf without this signed HIPAA consent form, therefore same day of service payment in full for any services will be required.

This HIPAA Consent was signed by:

__________________________  ______________________
Signature of patient or guardian  Printed name

Relationship to the patient (if other than patient):

__________________________  ______________________
Please Print  Today’s Date

Signature of practice representative:  ____________________________________________