Maple Avenue Pediatrics, P.A.
23-00 Route 208 • Fair Lawn, New Jersey 07410 • Telephone: (201) 797-1900

# HIPAA PRIVACY POLICY

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about Maple Avenue Pediatrics' patients be used and disclosed, and how you can get access to this information. Please review carefully. A more extensive version of this Notice is available upon request.

Maple Avenue Pediatrics has established a procedure to address concerns regarding privacy issues.

During treatment at this office, doctors, nurses and other caregivers may gather information about your medical history and health. This Notice explains how such information used and shared with others. It also explains privacy rights regarding this kind of information.

All patients of this office are children. When we refer to "you" or "your" in this Notice, we refer to the patient. When we refer to types of disclosures of information to "You", we mean disclosures to the patient, the patient's guardian or the person legally authorized to receive information about the patient.

Medical information may be used for the following purposes:

Treatment: We may use and disclose the patient's information to provide, coordinate and manage care and treatment. For example, a physician may share medical information with another physician for consultation or a referral.

Payment: We may use and disclose the patient's information to receive payment for the services we provide. For example, we will disclose information in order to submit claims to insurance companies.

Health Care Operation: We may use the patient's information to support certain business activities related to the functioning of our practice. For example, we may use information for quality assurance activities.

Appointment Reminders and Other Health Information: We may use information for reminder of future appointments. Information may be used to provide information about treatment alternatives or other health-related services that may be of interest.

Family Members or Other Responsible People: We may disclose information to people who will be taking care of the patient or are responsible for paying the bills, such as other family

members. We may also use information to let other family members know what the patient's general medical condition is. If the patient is able to make their own health care decisions, this practice will ask their permission before using medical information for these purposes. If the patient is unable to make health care decisions, this office will disclose relevant medical information to family members or other responsible people, if we feel it is in the patient's interest to do so. For example, we may provide limited medical information to a family member to pick up a prescription.

Emergency Conditions: We may use the patient's information in the event of an emergency treatment situation.

Others Uses or Disclosures: We have listed other instances where a patient's information may be disclosed. Those, instances included but are not limited to, when required by law for public health activities, relating to victims of abuse/neglect/domestic violence, for health oversight activities, for judicial and administrative proceedings to the extent by the law, for enforcement as permitted or required by law, to coroners/medical examiners/funeral directors as permitted by law, for organ donation purposes, for research purposes under certain circumstances, to advert a serious threat to health or safety, for certain specialized government functions such as military discharge and national security and intelligence and for workers' compensation purposes.

This practice will not use or disclose medical information in any other way without written permission. If we are given written permission to use or disclose the patient's medical information for another purpose, this permission can be revoked at anytime in writing.

PRIVACY RIGHTS:

Right To Restrict Use and Disclosure: You may request that this office not use medical information in certain ways or for certain purposes. You may also request that this office not provide medical information to certain people. However, this practice has the right to refuse your request.

Right To Confidentiality: You may request that this office provide you with your medical information in a confidential manner. For example, you can request that we send bills and other mailings to a different address or that we call appointment reminders to a different phone number. You must make this request in writing and specify another address or phone number. We will accommodate reasonable requests.

Right To Inspect and Obtain Copies: You may ask to see and obtain copies of medical records, unless that information is protected by law. The request must be in writing with signature consent. If we deny the request, you have the right to have the denial reviewed by your health care professional. We will act upon your request within 30 days.

Right to Amend Medical Records: You may ask us to amend information in the patient's medical records. If your request is denied, you can write a statement of disagreement with the denial that we will keep with your medical information.

Right To A Paper Copy: If you are viewing this Notice on our website, we will provide you with a printed copy of this Notice upon your request.

If you feel your medical information privacy rights have been violated, please contact your health care provider. If your concern remains unresolved, a complaint may be filed with the Secretary of Health and Human Services and/or with the practice's manager. Filing a complaint will not affect the quality of the services you receive from this practice and you will not be retaliated against for filing a complaint.

The effective date of this Notice is April 14, 2003. The practice is required to abide by the terms of this Notice. This practice reserves the right to change the terms of this Notice and to make new provisions effective for all protected health information maintained by this practice. If the terms of this Notice are changed, this practice will provide individuals with a revised Notice at the time of treatment or upon request. The revised Notice will be posted in the patient waiting area and the practice website.

Tova Yellin, M.D. F.A.A.P.
Kathleen Greaney, M.D. F.A.A.P.
Brian Lewis , M.D. F.A.A.P.

# Acknowledgment of Receipt of Notice of Privacy Practices:

I have received this office's Notice of Privacy Practices, which explains how my child(ren)'s medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ **(Signature)**

PATIENT PRIVACY QUESTIONNAIRE:

1. Please list the family members or other persons, if any, whom we may inform about your child/children's general medical condition and diagnosis (including treatment, payment, and health care operations:

   _____

   _____

2. Please list the family members or other persons, if any, who have your permission to bring your child/children.

   _____

   _____

3. Please list the family members or other person, if any, whom we **may not** inform about your child/children's general medical condition and diagnosis (including treatment, payment, and health care operations) :

   _____

4. Please print the telephone number where you want to receive calls about your child/children's appointments, lab, x-ray results, Insurance and Billing matters, and other health care issues: _____. If there is an alternate number please print it here: _____. Please be aware messages will be left on voice mail or answering machine unless otherwise directed.

   **I AM FULLY AWARE THAT A CELL PHONE IS NOT A SECURE AND PRIVATE LINE.**

5. Can confidential messages including but not limited to appointment reminders be left on your telephone answering machine or voice mail? ____yes ____no

**Signature of parent/legal guardian** _____ **Date:** _____
**Name:**_____ **Legal Relation to child(ren)**_____

**List name(s) of child(ren) covered by this form:**

_____

_____

**Release of Records:**

I authorize the release of Routine Childhood Immunization Records, sports forms and camp forms to Schools, day care and camps.

**Signature of parent/legal guardian** _____ **Date:** _____
**Name:**_____ **Legal Relation to child(ren)**_____

**Permission to Display Photos:**

I authorize and allow Maple Avenue Pediatrics, P.A. to display pictures of my children that I send to them in form of birth announcements, Holiday cards, and calendar forms to be posted on our family photo boards. ___yes ___no

**Signature of parent/legal guardian** _____ **Date:** _____
**Name:**_____ **Legal Relation to child(ren)**_____

# MAPLE AVENUE PEDIATRICS, PA – PATIENT INFORMATION FORM

PLEASE READ CAREFULLY AND FILL OUT ***ALL*** FIELDS

PLEASE LIST THE NAMES OF ***ALL*** CHILDREN COVERED BY THE ***BELOW*** INSURANCE INFORMATION

LAST NAME: _____ FIRST NAME: _____ DOB: _____ SEX: M___ F_____

LAST NAME: _____ FIRST NAME: _____ DOB: _____ SEX: M___ F_____

LAST NAME: _____ FIRST NAME: _____ DOB: _____ SEX: M___ F_____

LAST NAME: _____ FIRST NAME: _____ DOB: _____ SEX: M___ F_____

LAST NAME: _____ FIRST NAME: _____ DOB: _____ SEX: M___ F_____

LAST NAME: _____ FIRST NAME: _____ DOB: _____ SEX: M___ F_____

**PARENT OR LEGAL GUARDIAN #1: THIS PERSON AUTHORIZES TREATMENTS, ACCEPTS FINANCIAL RESPONSIBILITY, AND RECEIVES BILLING STATEMENTS**

RESPONSIBLE PARENT NAME _____RELATION TO PATIENT: ____ Mom ____ Dad ____Legal Guardian

DATE OF BIRTH: _____/_____/_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CONTACT # ☐ HOME: _____ ☐ CELL: _____ ☐ WORK: _____

E-MAIL: _____

OCCUPATION: _____ EMPLOYER NAME: _____

**PARENT OR LEGAL GUARDIAN #2**

PARENT NAME _____ RELATION TO PATIENT: _____ Mom _____ Dad ____ Legal Guardian

DATE OF BIRTH: _____/_____/_____

ADDRESS: _____

CITY: _____STATE:_____ZIP CODE: _____

CONTACT # ☐ HOME: _____ ☐ CELL: _____ ☐ WORK: _____

E-MAIL: _____

OCCUPATION: _____ EMPLOYER NAME: _____

CHILDREN PRIMARILY LIVE WITH: ☐ BOTH PARENTS ☐ MOTHER ☐ FATHER ☐ OTHER _____

EMERGENCY CONTACT PERSON: _____ PHONE # _____

ADDRESS: _____ RELATIONSHIP: _____

**INSURANCE INFORMATION**

INSURANCE COMPANY: _____LABORATORY: _____

STREET ADDRESS _____ CITY_____ STATE_____ ZIP_____

MEMBER ID # _____ EFFECTIVE DATE _____ COPAY_____

TYPE OF COVERAGE_____ GROUP # _____

**NAME OF POLICY HOLDER:** _____ D.O.B OF POLICY HOLDER _____

**SIGNATURE ON FILE:** I hereby authorize release of information to my insurance company and assign benefits otherwise payable to me, to the doctor indicated on the claim. I understand that I am financially responsible for all charges, including collection fees. NOTE: It is our policy to file insurance ONLY when we are a participating provider in a specific insurance plan. However, we need a signature on file for all patients. We do not submit to secondary insurance companies.

**SIGNATURE** _____ **DATE**_____

# INSURANCE ALERT

It is your responsibility to know your insurance benefits. If your insurance company denies a service because it is not part of your benefits you will be billed for the service.

For Example:

Copays - you need to know if you have a copay for WellCare visits. Many policies that previously waived the copay for well visits no longer do so.

Well visits - after the age of two, each insurance company has different rules as to the timing and number of Well visits that they will cover. Some plans only allow one well visit per the child's yearly age and some only allow one well visit until an exact year has passed. It is your responsibility to know the rules of your insurance plan and schedule your child's visit accordingly. If you schedule a well visit and your child's insurance company does not pay for it, you are responsible for the bill.

You are billed per the Explanation of Benefits (EOB) we receive from your insurance company. **If the insurance company does not pay for a rendered service, and the EOB states it is the patient/subscriber's responsibility, you will be billed.**

# MAPLE AVENUE PEDIATRICS
# BILLING POLICY

**PAYMENT**
FULL PAYMENT FOR SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED.
We accept cash, personal checks, MasterCard & VISA.

**HMO & MANAGED CARE PLANS**
Co-pay, if applicable, is due at the time services are rendered. There is an additional $10.00 fee if co-payment is not made when services are rendered. We will submit the claim to your insurance company. We will bill you for any balance indicated on your explanation of benefits. Payment is due within a month of the date we balance bill you. If you disagree with your insurance company's processing of your claim, you must contact them and then notify us if they agree to reprocess the claim. The relevant claim balance will still be considered "due from patient" until your insurance company actually reprocesses the claim.

Please note that even when we are participating providers in your plan, you may be responsible for amounts other than your co-pay or coinsurance, such as fees for well care visits or immunizations not covered under your plan or deductible amounts, etc. **It is in your best interest to clearly understand the terms of your plan before services are rendered.**

*NOTE THAT THERE ARE MANY DIFFERENT TYPES OF PLANS FOR EACH INSURANCE COMPANY. IT IS YOUR RESPONSIBILITY TO VERIFY WITH YOUR INSURANCE COMPANY THAT WE ARE PARTICIPATING PROVIDERS IN YOUR SPECIFIC PLAN. OUR DOCTORS' NAMES MAY APPEAR IN YOUR INSURANCE COMPANY'S LIST OF PARTICIPATING PROVIDERS AND YET WE MAY NOT PARTICIPATE IN YOUR SPECIFIC PLAN (THIS IS PARTICULARLY TRUE WITH BCBS PLANS).

**PATIENTS COVERED BY TWO PLANS**
If we are participating providers in your primary insurance plan, we will submit the claim to the primary plan only. We do not submit to secondary plans. Please note that your primary plan is generally the one where the subscriber has the earlier birthday in the calendar year (the insurance companies' "birthday rule"). Claims must be submitted to the primary carrier first.

**REFERRALS**
For services we advise you to obtain outside our office (specialist visits or lab tests), requirements vary among insurance plans. We cannot possibly keep abreast of each plan's provisions. **It is your responsibility to know and inform us of your specific plan's requirements**. Furthermore, while we will do our best to refer you to a specialist who participates with your insurance company, you must double-check that any specialist we refer you to is currently a participating provider in your specific plan. Please understand if services are provided by a non-participating specialist or lab or if you obtain services not covered by your specific plan, you will be responsible for the fees billed by the provider.

For non-urgent referrals please call our office Mondays thru Friday between 9:00 and 1:00.

**RESPONSIBLE PARENT**
In cases of divorced or separated parents, our policy is that the parent or guardian bringing the child into our office must ensure that we receive payment.

Our billing office is open 9:00-5:00 to answer any questions, 201-797-5579. However, please understand that we cannot be familiar with the specific terms of every policy issued by every insurance company, and you should address your **specific** questions to **your insurance company**.

Additional charges provided on separate sheet.

SIGNATURE OF PARENT OR GUARDIAN_____DATE_____

PRINTED NAME_____rev 9/23/04

# MAPLE AVENUE CHARGES

| | |
|---|---|
| Consultation letters/reports | **$25.00** |
| Early Intervention Form | **$25.00** |
| Forms needed within 48 hours | **$20.00 in addition to any other fees incurred** |
| No-show fee, doctor appointment<br>24-hour notice must be given for cancelled appointment | **$25.00** |
| No-show fee, nurse appointment<br>24-hour notice must be given for cancelled appointment | **$15.00** |
| Copy of chart fee | **$25.00 per child** |
| Bounced check fee | **$30.00** |
| Co-pay not paid at time of service | **$10.00** |
| Fee for bills not paid within 30 days | **$10.00 per month** |
| Physical exam form (school/camp, etc.)<br>**A Universal Form will be filled out at time of annual well visit and provided *free of charge*.** Patients must make additional copies of this form for their own records. If you have joined the patient portal, a copy of your universal form will be available under forms for you to print out at any time free of charge. | **$5.00 for each additional or duplicate forms** |
| Allergy & Asthma Forms<br>The charge applies for each allergy and asthma form that is filled out. | **$5.00** |
| Sports Physical Form<br>The charge applies for sports physical forms that are required by the State of New Jersey. **If the sports form is not filled out at the well visit, there will be a $20 charge.** If you have joined the patient portal, a copy of your sports form will be available for you under forms to print out at any time free of charge. | **$10.00** |

GUARANTOR SIGNATURE: _____ DATE: _____



# Maple Avenue Pediatrics, P.A.

23-00 Route 208 • Fair Lawn, New Jersey 07410 • Telephone: (201) 797-1900


## Maple Avenue Pediatrics
## Policy – Forms

We will provide one **Universal Health form** at no charge at the time of your child's yearly physical appointment. The Universal Health form can be copied and used for school, camp, etc. for the year between physicals. Please remember to keep a copy for yourself, you will be charged if additional forms are needed.

For children who need a **Sports form**, there will be a $10 charge. One sports form will be completed at your child's yearly physical. Part A of the sports form must be completed by a parent, prior to or during your visit. The sports form can be printed from our website: **www.mapleavepediatrics.org.**

## Fees

- **$5.00** charge for **any** mailed, faxed or dropped off forms to be completed.
- **$20.00** charge for **any** mailed, faxed or dropped off forms that must be completed within 48 hours.
- **$0.00** charge for one **universal form** completed **during** your child's well exam.
- **$10.00** charge for one **sports form** completed **during** your child's well exam
- **$20.00** charge for **sports forms not** completed at your child's well exam.

I have read and understand the above policy.

Patient Name: _____

Parent/Guardian signature: _____

Date: _____

3/12