PALMETTO PEDIATRICS OF CONWAY

Brian M. Rabon, MD *Board Certified*
Stephen J. Malloney, DO *Board Certified*
Elizabeth C. Drake, CPNP
140 Professional Park Drive * Conway, SC 29526 * Phone: (843) 234-5678 * Fax (843) 234-4567

New Patient Information

Office Hours: Monday-Friday 9:00 to 5:00 (Closed daily for lunch 12pm-1:45pm)
CLOSED Saturday & Sunday

Appointment/Walk-Ins Policy: All patients need an appointment to be seen. Calling ahead, even for same-day sick visits, allows us to better serve all of our patients with minimal wait times. Walk-ins will be worked in BEHIND appointments and may result in much longer wait times than if you had called ahead.

Insurance: We accept/file most major insurance plans. If your commercial insurance plan is not listed below, please check with your carrier to determine your coverage and potential out-of-pocket costs. If your Medicaid plan is not listed, we will not file it and you will be treated as a Self Pay patient and responsible for charges at the time of the visit.

Commercial Insurance

☑ Aetna
☑ Blue Cross Blue Shield- All Plans
☑ Blue Choice
☑ Carolina Care Plan
☑ ChampVA
☑ Cigna
☑ Medcost
☑ Planned Administrators/PAI
☑ United Healthcare

Medicaid Plans

☑ First Choice (Managed Care) *
☑ South Carolina Solutions (Medical Homes Network)
☑ Medicaid Fee-for-Service
☑ BlueChoice Medicaid

* First Choice is our preferred plan. **Please select this plan.** If you fail to select a plan, SC Healthy Connections will choose one for you and you will be responsible for any balances incurred as a result.

Typical Well Visits during the First Year:

2 Weeks	4 Months	9 Months
2 Months	6 Months	12 Months

Vaccinations begin at the 2 month visit. Please be aware that it is very important for you to keep these visits due to the vaccination requirements and developmental evaluations.

PATIENT POLICIES

FOR

Palmetto Pediatrics of Conway, Inc.

Brian M. Rabon, MD
Stephen J. Malloney, DO
Elizabeth C. Drake, CPNP
140 Professional Park Drive Conway, South Carolina 29526
(843) 234-5678 phone (843) 234-4567 fax

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully and initial.* If you have any questions, do not hesitate to ask a member of our staff.

Appointments

1) Our office hours are as follows: MONDAY-Friday 9:00 to 12:00 and 2:00 to 5:00pm.
2) We value the time we have set aside to see and treat your child. If you are not able to keep an appointment, we would appreciate 24-hour notice. If you no show for more than 3 appointments, you may be discharged from the practice.
3) We encourage parents and caregivers to call ahead for scheduling of same day visits! Same-day sick appointments will be made in the first AVAILABLE slot. This will help the staff and physicians minimize any unnecessary waiting for families. **Walk-ins will be seen as soon as possible, but appointments and call-ins will be seen first!**
4) If you are late for your appointment (>15 minutes), it may be necessary to reschedule your appointment.
5) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
6) Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (well-child) visit.
7) Holiday closings will be posted on our door or our telephone voicemail, please feel free to call in advance for information. There may also be times during the summer and holidays when our office hours are adjusted slightly.

Initial: _____

Insurance Plans

1) All patients will need to bring all current insurance cards/information and be prepared to pay their deductible, co-pay or percentage at each visit. Payment plans are available and prior arrangements can be made upon parent's request.
2) It is your responsibility to understand your benefit plan with regard to covered services, particularly coverage for vaccinations.

Initial: _____

Referrals

1) Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days.
2) It is your responsibility to know if a selected specialist participates in your plan.
3) Remember, we must approve referrals before they are issued.

Initial: _____

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
2) Co-payments and any estimated coinsurance are due at the time of service.
3) Self-pay patients are expected to pay for services in FULL at the time of the visit. We do offer a 50% discount for self-pay patients.
4) For scheduled appointments, prior balances must be paid or payment arrangements verified prior to the visit.
5) We accept cash, checks, Visa, MasterCard, and Discover.
6) A $30 fee will be charged for any checks returned for insufficient funds.

Initial: _____

Prescription Refills

1) For monthly medication refills, we require 48 hours notice, during regular business hours. Please plan accordingly.

Initial: _____

Transfer of Records

1) It is our desire to be your child's sole healthcare provider. Once a Release of Medical Records has been completed with your signature and records are transferred to another PRIMARY CARE PHYSICIAN, that child is no longer considered a patient in this practice. It is our policy that we do not accept these patients back once records have been sent to another local physician.

Initial: _____

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)_____

Responsible Party Member's Name _____Relationship_____

Responsible Party Member's Signature _____ Date _____

A copy of these policies will be provided to you for your reference.

Palmetto Pediatrics of Conway

Patient Information

Date _____
Patient Name _____ male/female (circle one)
Preferred name or nickname _____
Date of Birth _____
Social Security Number _____
Address _____
_____
Home phone _____
Primary Insurance _____ Secondary Insurance _____

Parent/Guardian Information

Father's Name _____ DOB _____
Social Security Number _____
Employer _____
Occupation _____
Work phone _____
Cell phone _____
Home address (if different from patient)
_____
_____

Mother's Name _____ DOB _____
Social Security Number _____
Employer _____
Occupation _____
Work phone _____
Cell phone _____
Home address (if different from patient)
_____
_____

In case of an emergency, please list three contacts other than parent/guardian:

Name	Relationship	Phone
1)		
2)		
3)		

Palmetto Pediatrics of Conway

Patient Medical History

Patient Name _____ Date of Birth _____

Birth Weight _____ Hospital Born In _____

Allergies _____

Chronic or recurrent illnesses _____

Current Medications _____

Hospitalizations since birth _____

Significant injuries _____

Surgeries _____

Family History

(circle all that apply)

Diabetes	Rheumatologic disease	Anemia	Asthma
Cancer	Psychiatric illness	Heart disease	
Seasonal allergies/Hay fever		Other _____	

Social History

Does child attend school or daycare? _____ Where? _____

Are parents divorced or separated? _____

If yes, with whom does child live with? _____

Number of siblings and age _____

Are there any special social circumstances we at Palmetto Pediatrics of Conway should be made aware of regarding your child? _____

_____

_____

NOTICE OF PRIVACY PRACTICES FOR

PALMETTO PEDIATRICS OF CONWAY
140 PROFESSIONAL PARK DR.
CONWAY, SC 29526
(843)234-5678
FAX (843)234-4567

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

Introduction

At Palmetto Pediatrics of Conway, Inc., we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Palmetto Pediatrics of Conway, Inc., a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care & treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state & nation,
- A source of data for our planning & marketing,
- A tool with which we can assess & continually work to improve the care we render & the outcomes we achieve,

Understanding what is in your record & how your health information is used to help you to:
Ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Palmetto Pediatrics of Conway, Inc., the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect & copy your health record as provided in 45 CFR 164.528,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses & disclosures of your information as provided by 45 CFR 164.522,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Palmetto Pediatrics of Conway, Inc. is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties & privacy practices with respect to information we collect & maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices & to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to procedures included in the authorization.

For More Information or to Report a Problem

If you have any questions & would like additional information you may contact the practice's Privacy Officer at (843) 234-5678. If you believe your privacy rights have been violated you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independent Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

** We will use your health information for treatment.*

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took & their observations. In that written the physician will know how you are responding to treatment.

** We will use your health information for payment.*

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

** We will use your health information for regular health operations.*

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care & outcomes in your case & others like it. This information will then be used in an effort to continually improve the quality & effectiveness of the healthcare & service we provide.

** Business associates*: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department & radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do & bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

** Notification*: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, & general condition.

** Communication with family*: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. You may request restrictions on disclosing your health information.

** Research*: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal & established protocols to ensure the privacy of your health information.

** Funeral directors*: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

** Organ procurement organizations*: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

** Marketing*: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits & services that may be of interest to you.

** Fund raising*: We may contact you as part of a fund-raising effort.

** Food and Drug Administration (FDA)*: We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product & product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

** Workers compensation*: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

** Public health*: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

** Law enforcement*: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards & are potentially endangering one or more patients, workers or the public.

Acknowledgement of Receipt of this Notice: **We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you choose not to sign, or are not able to sign, a staff member will sign their name & date. This acknowledgement will be filed with our records. Thank you.**

Acknowledgement of Receipt of Notice of Privacy Practices

I, **X**_____, have received the Notice of Privacy Practices from Palmetto Pediatrics of Conway, Inc.

X_____ **Date:** _____

Signature of Patient/Parent/Guardian

In lieu of patient signature, I, _____ a staff member of Palmetto Pediatrics of Conway,

Inc., state that **X**_____ has been given our current Notice of Privacy Practices.

X_____ Date: _____

Staff Member Signature

Authorization to Release Information

I, **X**_____ hereby authorize Palmetto Pediatrics of Conway, Inc. to release the following information: Appointment notices, Prescription and Sample Pick-up, Lab Results, Inquiries on Insurance Information, and Notices of Collections to the specified individuals below. (Before Palmetto Pediatrics of Conway, Inc. will release any private health information the following individuals will have to verify relationship and knowledge of patient.)

1._____

Name of Individual **Relationship to Patient** **Phone Number**

2._____

Name of Individual **Relationship to Patient** **Phone Number**

3._____

Name of Individual **Relationship to Patient** **Phone Number**

Palmetto Pediatrics of Conway, Inc. may leave messages on my recorder at home, mail notices to my home address and call me at work.

I hereby authorize the attending and consulting physicians to release information concerning my treatment to any insurance company requesting the same for purposes of determining eligibility for payment of insurance benefits.

AND

I hereby authorize payment to Palmetto Pediatrics of Conway, Inc. the charges associated with my treatment or diagnosis for any benefits specified and otherwise payable to me, but not to exceed the reasonable and customary charges. I understand that I am financially responsible to this company for charges not covered by this assignment.

You have the right to request that we restrict how protected health information about you is disclosed. If you have restrictions, please ask a member of our staff for the Form to Request Restrictions on Use and Disclosure of Protected Health Information.

X_____ **Date**_____

Palmetto Pediatrics of Conway

PATIENT NAME: _____
LAST FIRST MI OTHER NAME

DATE OF BIRTH: ____-____-____ SS#: ____-____-____ MEDICAL RECORD #: _____
MO DAY YR

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

I hereby authorize:

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

To release information from my medical record as indicated below to:

NAME: PALMETTO PEDIATRICS OF CONWAY

ADDRESS: 140 PROFESSIONAL PARK DRIVE CITY: CONWAY STATE: SC ZIP: 29526

PHONE: (843)234-5678 FAX: (843)234-4567

INFORMATION TO BE RELEASED:

	DATES:
☐ History and physical exam	_____
☐ Progress notes	_____
☐ Immunization record	_____
☐ Lab/X-ray reports	_____
☐ Other:_____	_____

I specifically authorize the release of information relating to:

☐ Substance I specifically abuse (including alcohol/drug abuse)

☐ Mental health (including psychotherapy notes)

☐ HIV related information (AIDS related testing)

X_____

SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

PURPOSE OF DISCLOSURE:

☐ Changing physicians ☐ Legal ☐ School ☐ Workers Compensation ☐ Other: _____

1. I understand that this will expire30 days after I have signed the form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am being requested to release this information by Palmetto Pediatrics of Conway, Inc. for the purpose of_____.
   a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
   b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I signed it.
   c. I have been informed that Palmetto Pediatrics of Conway, Inc.☐ will☐ will not receive financial or in kind compensation in exchange for using or disclosing the health information described above.
5. I understand that in compliance with South Carolina statue, I will pay a fee of $15.00. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

_____

SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN DATE