

CAPITAL AREA PEDIATRICS

A Patient Centered Medical Home

3937 Patient Care Dr. Suite 101

Lansing MI 48911

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We appreciate the opportunity to provide you with medical services. The information that follows is designed to answer the questions most frequently asked by our patients. We want you to know our policies and methods of practice.

If you have any questions, please ask us.

Capital Area Pediatrics Is a Patient Centered Medical Home

A **Medical Home** is a trusting partnership between a doctor-led health care team and an informed patient. It includes an agreement between the doctor and the patient that acknowledges the role of each in a total health care program.

We trust you, our patient, to:

- Tell us what you know about your child's health and illnesses
- Tell us about your needs and concerns and those of your child
- Take part in planning your child's care
- Follow the care plan that is agreed upon-or let us know why you cannot so that we can try to help, or change the plan
- Tell us what medications your child is taking and ask for a refill when you need one at your office visit
- Let us know when your child sees other doctors and what medication changes are made by another doctor
- Ask other doctors to send us a report about your child's care when you see them
- Seek our advice before you take your child to see other physicians
- We may be able to care for your child and we know about the strengths of various specialists
- Learn about wellness and how to prevent disease
- Learn about your insurance so you know what it covers
- Respect us as individuals and partners in your child's care
- Keep your appointments as scheduled, or call and let us know when you cannot
- Pay your share of the visit fee when you are seen in our office
- Give us feedback so we can improve our services

As a health care team, we will continue to:

- Provide same day appointments
- Provide your child with a care team who will know you and your family
- Respect you as an individual-we will not make judgments based on race, religion, sex, age, disability, etc.
- Respect your child's privacy-your child's medical information will not be shared with anyone unless you give us permission, or it is required by law
- Provide care with a team of people led by your child's physician
- Give the care your child needs when you need it
- Give care that meets your needs and fits with your goals and values and those of your child
- Have a doctor on call 24 hours a day and 7 days a week
- Take care of short illness, long term disease and give advice to help your child stay healthy
- Tell you about your child's health and illnesses in a way you can understand
- To improve your child's care, we are using technology--like our electronic medical records and electronic prescribing and we strive to continuously improve our use of technology

You may notice that as a health care team:

- We ask what your goal for your child is, or what you want to do to improve your child's health
- We ask you to help us plan your child's care, and to let us know if you think you can follow the plan
- You will be offered a summary of your visit
- Written copies of care plans may be given in more complex illnesses
- We remind you when tests are due so that your child can receive the best quality care

As part of our Patient Centered Medical Home orientation, we will ask you to acknowledge your agreement to the above and we will acknowledge our agreement to you. Our goal has been to provide excellent care for you.

It is our desire to continue to improve our services to you!

Practice Hours:

Monday through Friday 8:00am-5:00pm

Phone services available:

Monday through Friday 8 am to 12 noon and 1pm to 5 pm. We have an automated system so when you call you will hear a brief message with prompts to direct your call. You may speak with our receptionist to schedule appointments or leave a message regarding triage, refills, referrals, and billing concerns.

*Triage staff is available 8 am-noon and 1 pm – 4:30 pm. They are returned on an urgent basis as soon as possible.

*Voicemail for refill and referral lines are checked frequently each day. Please allow 72 business hours for requests to be completed.

Our voicemail boxes can be reached 24 hrs./day, 7 days a week. Messages left after 5 pm or on weekends will be reviewed the following business day. Please speak clearly and slowly, spell your child's name, and give the date of birth to enable our staff to help you more efficiently.

After hour services:

There is a physician available each night, weekend, and holiday to assist you with **urgent** concerns. You may reach the on-call physician by calling our office number **(517.394.6484)**. You will be prompted to leave your child's name and date of birth and briefly describe the problem. Please leave a phone number at which you can be reached. Please keep this line open to receive return calls. Our on-call staff will be paged and will return your call—striving to do so within 30 minutes. If you have not heard from us in that time, please call back and leave a second message. We ask that this service be used for matters that cannot wait until regular office hours.

Emergency Care and Urgent Care:

CAP strives to accommodate patients who need more urgent care. Please call us to see if we can see your child or to ask for guidance. If we are unable to see your child or feel that an emergency room or urgent care facility can serve you better, we will guide you to appropriate care.

Insurance Participation:

Your insurance policy is a contract between you and your insurance carrier or HMO. It is your responsibility to know what services are covered and your co-pay amount for physician office visits. CAP participates in many health plans. Your health plan probably covers preventive care such as well child exams and vaccines. CAP reviews health plans with your interests in mind.

- * Be prepared to present your insurance card and personal identification card at every office visit.
- * The person accompanying the patient is responsible for payment at the time of service. Be prepared to pay any charges not covered by your insurance. This includes deductibles, co-pays, or payment for non-covered services.
- * Register your NEWBORN on your insurance plan as soon as possible to help us maintain accurate billing—if this is not done within 30 days of birth—you may have to wait until the next open enrollment period with your employer.

If you have questions regarding a bill, please call our office @ 517.394.6484. You may leave a message on the billing office voicemail 24 hrs./day—be sure to leave your name and best phone number at which you can be reached.

Laboratory and Test Results:

Please try to use laboratories and other test facilities we use regularly to ensure better communication. We strive to get test results to patients. Please call if you have not heard from us within a week after the test(s) are done.

Welcome To Our Practice!

Capital Area Pediatrics, P.C. Financial Policy

Thank you for choosing Capital Area Pediatrics. We strive to provide the best quality care for our patients and families. Please carefully read the following, initial, sign and return to our office. Please contact our office if you have any questions.





1. It is your responsibility to know your benefits prior to any visit. To avoid unexpected balances, you should contact your insurance company prior to the visit to ensure that you know your benefits and limitations. In addition, while most insurance companies cover well child visits (including vaccines, screening, counseling, etc.) at no cost to you, your insurance plan may charge for additional procedures done during a well child visit. Furthermore, any additional health concerns discussed or addressed during a well child visit (outside of the growth and development of your child), your insurance company may consider these two separate visits and may apply a patient responsibility (depending on your benefits: copay, deductibles, co-insurances, etc.).

Some examples of procedures that may have an out-of-pocket expense (but not limited to):

- Photo Vision Screen
- Hearing Screen
- In-House Labs
- Umbilical Cord Chemical Cauterization
- Wart Removal
- Ear Wax Removal
- Abscess Drainage
- Telemedicine visits (video or phone)
- Online services through the portal
- Afterhours Phone Calls (On-Call or Other Parent-Initiated Calls)
- Travel Consults/Travel Vaccines
- Well Child Visits Combined with Other Non-Preventative Concerns (Behavioral Questions, Asthma Questions, Non-Preventative Questions, Medication Refills, Referrals, Labs, Other Procedures, Etc.)
- Additional Time Spent Evaluating and Addressing Non-Preventative Concerns
- Out-of-Network Services/Non-Covered Services
- Care Management

Initials: _____

2. It is your responsibility to provide our office with your current insurance information. Currently, we are asking all parents/guardians to provide all insurance cards and photo identification to update our records. In addition, please inform our office of any changes, such as change in insurance, address, phone number, etc.
3. **Important! Our office does not bill based on court documents. The person (parent/guardian/other) who brings the child to the appointment is responsible for any charges from that visit, including copays and additional expenses.** If your insurance is inactive and you

are considered "cash patient", payment is due at the date of visit/check-out. We are happy to accept     , cash, checks, and money orders. Payments can also be made by phone or through our Patient Portal.

4. Medicaid – We only accept Medicaid for established patients or if it is your secondary/tertiary insurance. We only participate with Straight Medicaid, Blue Cross Complete of Michigan, and McLaren Medicaid. If you have any other Medicaid Health Plan, your appointment may be cancelled, or you may have to pay out of pocket for a visit.
5. **New Patients – We do not accept Medicaid or any Medicaid HMO as primary insurance.** If your child converts to Medicaid as primary insurance within 90 days of their first visit they will be considered for discharge.
6. **Missed/No Show Appointment Policies:**
 - **Missed Appointment Policy** - If a scheduled appointment is missed, meaning cancelled with less than a 4-hour notice or you are more than 15 minutes late, it is considered a "Missed Appointment". Your family is allowed 3 Missed Appointments in a 12-month period and considered for discharge after the 3rd missed appointment.
 - **No Show Policy** - If you "No Show" for a scheduled appointment, meaning you did not call our office to let us know that you could not make the appointment, a **\$20.00 fee** will be charged to your account.

Initials: _____

7. Medical Records Fees (only for personal copies):
 - Paper: \$35.00 Maximum 35 pages (\$1.00 per additional page)
 - Compact Disc: \$35.00
8. Sports Physical Appointments: \$35.00
9. Returned Check Fee: \$40.00
10. FMLA Form Fee: \$35.00
11. Other Form Fees: Amount charged is at the provider's discretion.

Failure to follow any of the above conditions may result in the discharge of your family.

Assignment of Benefits: For all services rendered by Capital Area Pediatrics, P.C. I authorize my insurance to issue all payments directly to them. I understand that I am responsible for any amounts not covered by my insurance.

Effective Date of this Notice: February 2019

**Capital Area Pediatrics
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 individually identifiable health information (IIHI). 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 are also 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 IIHI. 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 IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI 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 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 always post a copy of our current Notice in our offices in a visible location, and you may request a copy of our most current Notice at any time.

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

**Capital Area Pediatrics
3937 Patient Care Drive, Suite 101
Lansing, MI 48911
(517) 394-6484**

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

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

1. Treatment. Our practice may use your IIHI 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 IIHI to write a prescription for you, or we might disclose your IIHI 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 IIHI in order to treat you or assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI 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 IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI 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 IIHI 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 IIHI 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 IIHI to other health care providers and entities to assist in their health care operations.

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

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

6. Health-Related Benefits and Services. Our practice may use and disclose your IHI 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 IHI 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 IHI when we are required to do so by federal, state, or local law.

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

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

1. Public Health Risks. Our practice may disclose your IHI 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 the information.

2. Health Oversight Activities. Our practice may disclose your IHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, 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 IHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your IHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have tried to inform you of this request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IHI 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 IHI 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. Organ and Tissue Donation. Our practice may release your IHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurance that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI 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.

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

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

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI 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 *Capital Area Pediatrics; 3937 Patient Care Drive, Suite 101; Lansing, MI, 48911; (517) 394-6484*; 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 for the use or disclosure of your IIHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI 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 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 IIHI, you must make your request in writing to *Capital Area Pediatrics; 3937 Patient Care Drive, Suite 101; Lansing, MI, 48911; (517) 394-6484*. Your request must be described 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 IIHI that may be used to make decisions about you, including patient medical records and billing records, but not psychotherapy notes. You must submit your request in writing to *Capital Area Pediatrics; 3937 Patient Care Drive, Suite 101; Lansing, MI, 48911; (517) 394-6484*; in order to inspect and/or obtain a copy of your IIHI. 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 *Capital Area Pediatrics; 3937 Patient Care Drive, Suite 101; Lansing, MI, 48911; (517) 394-6484*. 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 IIHI kept by or for the practice; (c) not part of the IIHI 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 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 IIHI for non-treatment, non-payment, or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor shares information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to *Capital Area Pediatrics; 3937 Patient Care Drive, Suite 101; Lansing, MI, 48911; (517) 394-6484*. 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 *Capital Area Pediatrics; 3937 Patient Care Drive, Suite 101; Lansing, MI, 48911; (517) 394-6484*.

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 regarding our practice, contact *Capital Area Pediatrics; 3937 Patient Care Drive, Suite 101; Lansing, MI, 48911; (517) 394-6484*. 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 IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI 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 or would like another copy of this notice, please contact:

Capital Area Pediatrics; 3937 Patient Care Drive, Suite 101; Lansing, MI, 48911; (517) 394-6484.

Capital Area Pediatrics, P.C.
Financial Policy

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Some examples of procedures that may have an out-of-pocket expense (but not limited to):

- **Evening Appointments** (appointments made at 5:00 pm or after)
- **Photo Vision Screen**
- **Hearing Screen**
- **In-House Labs**
- **Umbilical Cord Chemical Cauterization**
- **Wart Removal**
- **Ear Wax Removal**
- **Abscess Drainage**
- **Telemedicine visits** (video or phone)
- **Afterhours Phone Calls (On-Call or Other Parent-Initiated Calls)**
- **Travel Consults/Travel Vaccines**
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- **Additional Time Spent Evaluating and Addressing Non-Preventative Concerns**
- **Out-of-Network Services/Non-Covered Services**
- **Care Management**

Initials: _____

2. It is your responsibility to provide our office with your current insurance information. Currently, we are asking all parents/guardians to provide all insurance cards and photo identification to update our records. In addition, please informed our office of any changes, such as change in insurance, address, phone number, etc.
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 - Paper: \$35.00 Maximum 35 pages (\$1.00 per additional page)
 - Compact Disc: \$35.00
8. Sports Physical Appointments: \$35
9. Returned Check Fee: \$40.00
10. FMLA Form Fee: \$35.00
11. Other Form Fees: Amount charged is at the provider's discretion.

Failure to follow any of the above conditions may result in the discharge of your family.

Assignment of Benefits: For all services rendered by Capital Area Pediatrics, P.C. I authorize my insurance to issue all payments directly to them. I understand that I am responsible for any amounts not covered by my insurance.

I _____, parent of _____

have read, understand, and agree to this Financial Policy for all my children seen at Capital Area Pediatrics, P.C.:

Guarantor's Signature:

Date: _____

Guarantor's Relationship to the Child: () Father () Mother () Guardian () Other: _____



Capital Area Pediatrics, P.C.
Portal Invite

Optional: Please provide your email address to send/receive secure messages from our Patient Portal:

Office Use Only:

Pat#:

Pat#:

Pat#:

Pat Name:

Pat Name:

Pat Name:

Pat#:

Pat#:

Pat#:

Pat Name:

Pat Name:

Pat Name: