104 Fairview Park Drive Dublin, GA 31021
Phone: (478) 304-1414 Fax: (478) 353-1353

HOPE Pediatrics, LLC Practice Policies

Clinic Information:
Hours: Monday -Friday 8:00 am to 5:00 pm (Subject to Change)
Address: 104 Fairview Park Drive, Suite 200, Dublin, GA 31021
Phone Number: 478-304-1414
Fax: 478-353-1353
Website: www.hopedublin.com-includes link to patient portal.

After Hours Policy:
If our office is closed, we encourage you to call us! Call 304-1414, leave a voicemail for one of our on-call pediatricians. Dr. Moorman or Dr. Helton will do their best to return your call within 1 hour. Communicating directly with our doctors to address your concerns is a more efficient way of diagnosing your child and treating them than using a traditional emergency room or urgent care center. We have immediate access to your child's DOB, weight, pharmacy, allergies and problem list. We encourage you to use your medical home at HOPE Pediatrics for medical advice first. However, if you feel your child must be seen immediately, we recommend you take them to Fairview Park Hospital. Be sure to let them know we are your primary care provider and they will keep us informed with any information we may need to treat your child when you are released from their care. This policy helps us to retain continuity of care and avoid costly and unnecessary emergency room and urgent care visits.

Hospitalization:
If you are hospitalized, please let the hospital know we are your primary care physician. At Fairview Park Hospital our office has a designated hospital doctor who takes care of our patients. You may access our portal via our website www.hopedublin.com to relay any medical records.

Patient Responsibilities:
- Let us know when you see other providers and what medications they put you on or change.
- When seeing specialists or other physicians, please have them send us a report about your care.
- Follow the care plan that is agreed upon by other providers. If you feel it is not suitable or have any concerns, please let us know so we can make adjustments.
- Please make sure to notify us if you change insurance. Also, it is your responsibility to contact your insurance company to make sure we are in-network with your plan and benefits.

Clinic Policies:
- Prescription Refill Policy: Most refills for prescriptions are handled at the time of the visit. You may also request refills online once the patient portal has been activated for you. However, an office visit may be required depending on your situation. For any new medications, which this office has not prescribed before, an appointment is required. Any refills made on weekends will incur a $25 after hours charge.
- Controlled Substances/ADHD Medications Policy: We will refill monthly for 3 months or on the 4th month with forms or our physicians will extend 1 month with up to 48 hours turnaround. We do not prescribe certain medications for long term daily use including certain pain medications

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(i.e. Oxycodone, Morphine, Percocet, Vicodin), anxiety medications (i.e. Xanax, Valium, Klonopin) and certain sleep medications (i.e. Ambien, Lunesta). You will need to be managed by a specialist for these conditions if you need to be on them for daily use.

- ***No Show and Late Policy: It is the patient's responsibility to keep your appointment as scheduled or call and let us know when you cannot. We reserve the right to charge up to $50 if you do not contact us at least 24 hours before your scheduled appointment time. In addition, if you arrive late to your scheduled office visit, we will let you know if we are still able to see you. You may be required to wait longer or re-schedule your appointment if you are more than 15 minutes late. This is done in order to ensure a decreased waiting time for other patients who arrive on time. After 3 no show appointments within a year, you will be dismissed from our practice.***

The Practice as a whole will continue to:

- Respect you as an individual-We will not make judgments based on race, religion, sex or disability.
- Respect your privacy- Your medical information will not be shared with anyone unless you give us permission unless required by law.
- Provide care given by a team of people led by your doctor based on quality & safety.
- Have a doctor on-call 24 hours a day, 7 days a week for emergency issues.

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Patient Information Form

Patient Full Legal Name_____
Nickname:_____
Date of Birth:____/_____/_____ Sex: ____M ____F
Address:_____
City:_____ State:_____ Zip:_____
Phone: ( )_____ Social Security# _____

Race/Ethnicity: ___ White ___Black/African American ___ Asian ___ Pacific Islander
___Native American ___ Hispanic/Latino ___ Other ___ Decline ____

Parent/Legal Guardian Name 1:_____
Relationship to Patient: _____
Date of Birth: ____/_____/_____ Social Security # _____
Mobile Phone: ( )_____ Work Phone: ( )_____
Email Address:_____
Employer:_____ Occupation: _____
Home Address (if different from child):_____
City:_____ State:_____ Zip:_____

Parent/Legal Guardian Name 2 :_____
Relationship to Patient: _____
Date of Birth: ____/_____/_____ Social Security # _____
Mobile Phone: ( )_____ Work Phone: ( )_____
Email Address:_____
Employer:_____ Occupation: _____
Home Address (if different from child):_____
City:_____ State:_____ Zip:_____

Primary Insurance _____
Primary Card Holder Name _____
Subscriber ID Number_____
Subscriber Date of Birth____/___/_____
Subscriber Social Security #_____

Secondary Insurance _____
Primary Card Holder Name_____
Subscriber ID Number_____
Subscriber Date of Birth____/___/_____
Subscriber Social Security #_____

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Communication: Use and Disclosure Authorization

Patient Name: _____ Date of Birth: _____

I hereby request the following regarding the use of my PERSONAL HEALTH INFORMATION:

1. You may leave the following messages on answering machines:

- ❑ Referral Information
- ❑ Prescription refill information
- ❑ Other: _____
- ❑ Test results
- ❑ Appointment Reminder

2. You may discuss information regarding my treatment and care with the following family members and/or friends: Please list relationship and contact number.

Name:_____ Relationship to Patient_____

Contact Number_____

Name:_____ Relationship to Patient_____

Contact Number_____

3. Is there anyone who is not authorized to have access to the patient or their information regarding their treatment and care?

Name:_____ Relationship to Patient_____

4. Would you like to be contacted for medical issues, reminders, recalls and general notices by text messages or email? Please check one: **____TEXT____EMAIL**

Email and Text Messaging Correspondence Authorization: In compliance with the HIPAA privacy rule, by signing below, I am authorizing in advance use of my confidential email to receive Hope Pediatrics LLC email notifications regarding future appointments as well as disease-specific health-related products/services. See our privacy policy.

SIGNATURE OF PARENT OR LEGAL GUARDIAN_____
CONFIDENTIAL EMAIL:_____
CONFIDENTIAL PHONE NUMBER:_____

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Notice of Privacy Practices

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

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain law suits and law enforcement.

Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.
- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request,

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we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary, to fulfill treatment and payment.

- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fund-raising communications.
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If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Hope Pediatrics, LLC
Phone (478) 304-1414
Fax (478) 353-1353
OR
Office for Civil Rights
https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

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CONSENT TO USE NAME, QUOTES AND/OR PHOTOS

I, _____, hereby give **Hope Pediatrics, LLC** the absolute and irrevocable rights to use my child's name, quotes and/or photos and images on the Internet (World Wide Web), in print publications, video and multimedia presentations, and/or for any purpose which may include, but not limited to display, public relations, marketing, or designs.

I understand that my child's name and/or the images may be used for display or advertisement for the web site and/or literature published. I hereby waive the right to inspect or approve the images prior to any form of usage. I understand that the images may be modified to be used as design elements.

By signing this agreement, or by signing this agreement on behalf of a minor in the state of Georgia, I am giving **Hope Pediatrics, LLC** the right to use my child's name and own the images and use them for any purposes without further approval from me. I am releasing all rights to any images.

This agreement is a permanent licensing agreement that allows **Hope Pediatrics, LLC** to use any images, quotes and/or my child's name for any publishing purposes in the promotion of Hope Pediatrics, LLC I will not hold /or **Hope Pediatrics, LLC** responsible for any use or misuse of my name, quotes and/or the images. I agree to hold harmless, /or **Hope Pediatrics, LLC** from any and all actions, claims, and demands a rising out of or in connection with the use of all or any part of the photographs (including computer images or reproductions of any kind), including any editorial or comment which may accompany the images in their displayed format and/or my child's name. I will not hold **Hope Pediatrics, LLC** liable for any errors, negligence, or gross negligence, in the editing or displaying of said images, quotes and/or in the use of my child's name.

I certify, by signing below, that I am of legal age, 18 years of age or older or that I am the parent or legal guardian of the identified minor. I have read this agreement and fully understand the contents herein.

Information of parent or guardian if individual is under 18 years of age:

Parent/Guardian name (PRINT): _____

Parent/Guardian signature: _____

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CONSENT FOR EVALUATION/TREATMENT & PRACTICE POLICIES

The undersigned hereby consents to evaluation or treatment the assigned health care provider may deem necessary to the patient _____. I also state that I have read the Patient Agreement and agree to abide by the policies set forth by HOPE Pediatrics, LLC.

INSURANCE ASSIGNMENT

I hereby authorize the patient's insurance benefits to be paid directly to HOPE Pediatrics, LLC. I understand and agree that, regardless of the patient's insurance status, I am ultimately responsible for the balance on the patient's account for any professional services rendered.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I hereby acknowledge that HOPE Pediatrics, LLC has given me the opportunity to read a copy of their Privacy Practices.

_____ _____

PATIENT, PARENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE **DATE**