Coastal Healthcare

1659 Route 88 - Suite 2B
Brick, New Jersey 08724
(732)458-1211 Fax (732)836-3144

Notice of Privacy Practices

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

Coastal Healthcare (the "Practice"), in accordance with the federal Privacy Rule, 45 CFR parts 160 and 164 (the "Privacy Rule") and applicable state law, is committed to maintaining the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice and is often referred to as your health care or medical record. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

(a) **Treatment** – To provide you with the health care you require, the Practice may use and disclose your PHI to those health care professionals, whether on the Practice's staff or not, so that it may provide, coordinate, plan and manage your health care.

(b) **Payment** – To get paid for services provided to you, the Practice may provide your PHI, directly or through a billing service, to a third party who may be responsible for your care, including insurance companies and health plans. If necessary, the Practice may use your PHI in other collection efforts with respect to all persons who may be liable to the Practice for bills related to your care. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

(c) **Health Care Operations** – To operate in accordance with applicable law and insurance requirements, and to provide quality and efficient care, the Practice may need to compile, use and disclose your PHI. For example, the Practice may use your PHI to evaluate the performance of the Practice's personnel in providing care to you.

OTHER EXAMPLES OF HOW THE PRACTICE MAY USE YOUR PROTECTED HEALTH INFORMATION

(a) **Advice of Appointment and Services** – The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders may be used by the Practice: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

(b) **Family/Friends** – The Practice may disclose to a family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

(i) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.

(ii) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

OTHER USE & DISCLOSURES WHICH MAY BE PERMITTED OR REQUIRED BY LAW

The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

(a) **De-identified Information** – The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

(b) **Business Associate** – The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

(c) **Personal Representative** – The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) **Emergency Situations** – The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible: The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) **Public Health Activities** – The Practice may use and disclose PHI when required by law to provide information to a public health authority to prevent or control disease.

(f) **Abuse, Neglect or Domestic Violence** – The Practice may use and disclose PHI when authorized by law to provide information if it believes that the disclosure is necessary to prevent serious harm.

(g) **Health Oversight Activities** – The Practice may use and disclose PHI when required by law to provide information in criminal investigations, disciplinary actions, or other activities relating to the community's health care system.

(h) **Judicial and Administrative Proceeding** – The Practice may use and disclose PHI in response to a court order or a lawfully issued subpoena.

(i) **Law Enforcement Purposes** – The Practice may use and disclose PHI, when authorized, to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena, or if the Practice believes that your death was the result of criminal conduct.

(j) **Coroner or Medical Examiner** – The Practice may use and disclose PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(k) **Organ, Eye or Tissue Donation** – The Practice may use and disclose PHI if you are an organ donor to the entity to whom you have agreed to donate your organs.

(l) **Research** – The Practice may use and disclose PHI subject to applicable legal requirements if the Practice is involved in research activities.

(m) **Avert a Threat to Health or Safety** – The Practice may use and disclose PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(n) **Specialized Government Functions** – The Practice may use and disclose PHI when authorized by law with regard to certain military and veteran activity.

(o) **Workers' Compensation** – The Practice may use and disclose PHI if you are involved in a Workers' Compensation claim to an individual or entity that is part of the Workers' Compensation system.

(p) **National Security and Intelligence Activities** – The Practice may use and disclose PHI to authorized governmental officials with necessary intelligence information for national security activities.

(q) **Military and Veterans** – The Practice may use and disclose PHI if you are a member of the armed forces, as required by the military command authorities.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

You have the right to:

(a) Revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request special restrictions on certain uses and disclosures of your PHI as authorized by law. In general, this relates to your right to request special restrictions concerning disclosures of your PHI regarding uses for treatment, payment and operational purposes under Privacy Rule, Section 164.522(a) and restrictions related to disclosures to your family and other individuals involved in your care under Privacy Rule, Section 164.510(b). Except in certain instances, the Practice may not be obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

(c) Receive confidential communications or PHI by alternative means or at alternative locations as provided by Privacy Rule Section 164.522(b). For instance, you may request all written communications to you marked "Confidential Protected Health Information." You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

(d) Inspect and copy your PHI as provided by federal law (including Privacy Rule, Section 164.524) and state law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.

(e) Amend your PHI as provided by federal law (including Privacy Rule, Section 164.526) and state law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by federal law (including Privacy Rule Section 164.528) and state law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

(g) Request special authorization to allow the Practice to use and disclose your protected health information (PHI) for purposes other than those enumerated in this Notice of Privacy Practices (NPP). This request must be made in writing to the Practice's Privacy Officer.

(h) Receive a paper copy of this Privacy Notice from the Practice (as provided by Privacy Rule Section 164.520(b)(1)(iv)(F)) upon request to the Practice's Privacy Officer, or from this Practice's web site www.shorehealthgroup.com.

(i) Complain to the Practice or to the Secretary of HHS (as provided by Privacy Rule Section 164.520(b)(1)(vi)) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions you want answered about your privacy rights (as provided by Privacy Rule Section 164.520(b)(2)(vii)), you may contact the Practice's Privacy Officer as follows:

Coastal Healthcare
Attn: Privacy Officer
1659 Route 88, Suite 2B
Brick, New Jersey 08724
(732)458-1211 Fax (732) 836-3144

PRACTICE'S REQUIREMENTS

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE
This Notice is in effect as of 04/14/03.

Coastal Healthcare

FINANCIAL POLICY

Welcome to Coastal Healthcare. We would like to take this opportunity to inform you of our office financial policies.

Insurance and Billing:
We will bill insurance claims to primary and secondary carriers as a courtesy to our patients. You are responsible for providing us with up-to-date insurance information. If your insurance company requires referrals, advanced notification is required for non-emergent referrals. Also, when coming to a Coastal Healthcare specialist, you must have your referral before being seen or you will be responsible for payment in full at the time of service. We accept payment from all participating insurance plans, but require that you pay your co-pay at the time of service. You will be responsible for any deductibles, coinsurance and non-covered services. If you do not have insurance, payment for services is expected at the time of service. The office policy is that the parent requesting treatment for a minor child is responsible for all fees incurred. We cannot become involved in billing disputes in cases involving divorce or separation.

Insurance policies have become increasingly complex over the years and it has become impossible for our office to know each specific plan and their limitations. Therefore, it is your responsibility to know your insurance benefits. Your insurance policy is a contract between you and your insurance company. You may be billed in the event that your insurance plan does not pay in a timely manner or is unresponsive to our claims submission. All fees are ultimately your responsibility.

Charges/Fees:
All missed appointments with the doctor and those cancelled with less than 24-hour notice may be subject to a $25.00 fee. Also, in the event that a check is returned to us by your bank for any reason, there will be a $25.00 service charge. There may be additional charges, not covered by insurance, including form processing fees (i.e., physicals, disability), after-hours appointments, weekend appointments, appointments on holidays, and a processing fee on over 30 day unpaid balances ($10 per statement).

Collection Agency:
All patient accounts that become delinquent will be processed in-house for collection proceedings. A past due and final dunning notice will be sent for overdue accounts. The account will then be reviewed for referral to an outside agency. All accounts turned over to a collection agency will be assessed a 25% administrative fee.

Financial Hardship:
Financial hardship should not stand in the way of medical care. Please discuss hardship with the billing staff as soon as possible.

I HAVE READ AND UNDERSTAND THE TERMS AND CONDITIONS SET FORTH IN THE ABOVE POLICY.

_____ _____

Patient Name-Please Print Date

_____ _____

Patient or Parent Signature Relationship

Coastal Healthcare

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE
AND DESIGNATION OF DISCLOSURE FORM

1. **<u>Acknowledgement of Privacy Practice Notice</u>:**
   I have been offered a copy of ***Coastal Healthcare's*** Notice of Privacy Practices.

   Patient Name: _____ Date of Birth_____

2. **<u>I wish to be contacted in the following manner (check all that applies)</u>:**

   Home Telephone (OK to leave a detailed message) Number: _____
   □ Check if it is **not** ok to leave a detailed message on your answering machine and a message with only the Doctor's name and number will be left.

   Cell Telephone (OK to leave a detailed message) Number: _____
   □ Check if it is **not** ok to leave a detailed message on your cell phone and a message with only the Doctor's name and number will be left.

   Work Telephone (OK to leave a detailed message) Number: _____
   □ Check if it is **not** ok to leave a detailed message at work and a message with only the Doctor's name and number will be left.

   Written Communication: Unless otherwise instructed written communications will be mailed to the home address on file.

3. ***Coastal Healthcare*** operates as a multispecialty group with various offices that have access to your information and may exchange the details from our shared database.

4. **<u>Designation of Certain Relatives, Close Friends and Other Caregivers</u>:**
   I agree that ***Coastal Healthcare*** may disclose certain of my health information to a family member, close friend or other caregiver because such person is involved with my health care or payment relating to my healthcare. In that case, ***Coastal Healthcare*** will only disclose only information that is relevant to the person's involvement with my health care or payment relating to my health care.

   I designate the following person listed below as a person involved with my healthcare or payment relating to my healthcare for the purposes of ***Coastal Healthcare*** to make the type of disclosures listed above. (I understand that I am not required to list anyone and that I may change this list at any time in writing).

Print Name (<u>other than patient</u>) 1) _____ 2) _____

Relationship to Patient: 1) _____ 2) _____

Date of Birth: 1) _____ 2) _____

Telephone #: 1) _____ 2) _____

_____ _____
Signature of Patient/Parent/Guardian Date

Young Adult Confidentiality / Release Form
For Patients Age 18 Years and Older

Stepping Stone **Pediatrics**

Patient Name: _____

Date of Birth: _____

As a legal adult, I understand that all information that I discuss with my physician will be strictly confidential and any communications from Stepping Stone Pediatrics will be discussed with me directly. I also understand, however, that I may wish to authorize Stepping Stone Pediatrics to speak with my parent(s) or other guardian(s) regarding specific issues related to my medical care.

Ĭ I herby **authorize** Stepping Stone Pediatrics **to discuss** the following information (check all that applies):

- Ĭ Appointment scheduling
- Ĭ Medication requests/refills
- Ĭ Insurance / billing / referrals
- Ĭ Medical care/treatment/lab results with the EXCLUSION of any issues circled below
  (if circled we will NOT discuss with anyone but the patient)
  drug/alcohol usage, sexual health, HIV testing, AIDS testing,
  mental health treatment
  or _____(write in other specific information).

With the individual(s) listed below:

Name: _____ Relationship to patient: _____
Name: _____ Relationship to patient: _____

OR

Ĭ I do **NOT** authorize Stepping Stone Pediatrics to discuss any issues related to my medical care with my parents(s). Further, I understand that I must review and sign the Office Policy.

This authorization will expire once I have left Stepping Stone Pediatrics.

I understand that I may revoke this consent at any time by signing the Revocation Statement below, however such revocation does not affect any actions taken by Stepping Stone Pediatrics before I signed the Revocation Statement.

Patient Signature: _____ Date: _____

REVOCATION STATEMENT:

I revoke the above authorization as of the date listed below.

Patient Signature: _____ Date: _____

COASTAL HEALTHCARE

Stepping Stone **Pediatrics**

Office Policies

revised anuary

We are glad that you have made the Stepping Stone Pediatrics office of Costal Healthcare part of your extended family. In order to give all our children the best medical care possible, we have implemented the following office polices. If you have any concerns, comments or questions about them, please do not hesitate to discuss this with one of our staff members.

Hours

The office location Stepping Stone Pediatrics will be open Monday, Tuesday and Thursday from 9 am to 5 pm and on Wednesday and Friday from 9am to 1pm. **The staff will answer the telephone at appro imately : am** to assist with any issues that you might have. Please call to let us schedule an appointment time for your child that is mutually convenient for both of us. This will enable us to keep our waiting time to a minimum. We do not accept "walk-in" appointments for this reason.

Food and Beverages

We strive to maintain a friendly and inviting facility for your family. We request that with the exception of infants, there is no eating and/or drinking in our facility. Germs are easily shared by placing objects in one's mouth, including food. A pediatric office is not a good place to have our children consuming food.

Yearly Physicals

To ensure our patients' health, a physical exam is required annually after the age of three. During your child's yearly physical, much information is exchanged between your family and our staff. To ensure that your child receives thorough and complete medical care, we also recommend that a parent accompany all children under 18 years of age to their yearly physical.

School / Camp Physical forms

To ensure our children's health, we will complete physical forms only if we have seen the child within one year's time. You may fax, mail, or drop off any paperwork that you require us to complete on your child's behalf. We require three (3) business days to complete this paper work.

Referrals

It is your responsibility to know if a referral or authorization is required to see a specialist. We require three (3) business days to process any non-emergent referral requests. When making a referral request we need the name of the child, the specialist he/she is going to, the reason for the visit, the date of the visit, and the insurance company. For your convenience you may send us the needed information by visiting this office's website - www.steppingstonepediatrics.com - to complete an online form.

Signed: _____ Relation to children _____

Children's Names: _____ Date: _____

Young Adult Registration Information Sheet
Coastal Healthcare / Stepping Stone Pediatrics, LLC

Turning 18 is a major milestone for many reasons, one of which is the significant change to your rights and responsibilities as a patient. We are pleased that you have elected to continue obtaining your medical care from Coastal Healthcare / Stepping Stone Pediatrics. As a legal adult, however, we need you to sign and complete forms that pertain to your medical care. Please take a few minutes to fill out this form as completely as you can. This insures that we have **your most up to date** information. If you have questions we'll be glad to help you.

Patient Name: _____ Today's Date: _____

Date of Birth: _____

Cell Telephone: _____ **email**: _____

Primary /Permanent Address: _____
Street City Zip

College Address (if applicable): _____
Street City Zip

Name of College (if applicable) _____

Pharmacy(s): **Local** Name: _____, City: _____, Phone _____

College Name: _____, City: _____, Phone _____

Private Insurance Authorization Assignment of Benefits / Information Release

I, the undersigned , authorize payment of a medical benefit to Coastal Healthcare for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my insurance. I also authorize you to release to my insurance company information concerning healthcare, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claim benefits.

_____ _____
Signature of patient Date

ER History Consent:

I, hereby give Coastal Healthcare and its affiliated providers permission to view my prescription information and history for all external sources. By signing this consent form , I agree that Coastal Healthcare can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for all treatment purposes.

_____ _____
Signature of patient Date

Please continue on other side ----------→

In the 3rd column **BELOW** please place the following indicators of how **you** would like to be contacted about:

A = Appointment confirmation / reminder for an appointment already made

R = reminder that an physical is needed or a vaccine is due

B = Billing statements **note** only to mail address, text to cell, or email

G = general notices and medical issue

Self : Smoker: □ Yes □ No SS#: _____	Cell Phone (voice)	
	Text to cell phone	
	Email	

Mother's Information: Name: _____ Birth date: _____ Occupation: _____ SS#: _____ Smoker: □ Yes □ No Address if different than yours:	Cell Phone (voice)	
	Text to cell phone	
	Email	
	Work phone	
	Home land line:	
Father's Information: Name: _____ Birth date: _____ Occupation: _____ SS#: _____ Smoker: □ Yes □ No Address if different than yours:	Cell Phone (voice)	
	Text to cell phone	
	Email	
	Work phone	
	Home Land line:	

Insurance

Person Responsible for account _____ Relation to patient__ _____
Last Name First Name Middle

Primary Insurance Company _____ Phone _____

Are patients covered by secondary insurance? □ yes □ no

Secondary Insurance: If secondary insurance member is different from person responsible for account, please provide the following:

Person Responsible for account _____ Relation to child _____
Last Name First Name Middle

Secondary Insurance Company _____Phone _____